

AMERICAN MEDICAL TIMES

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A preliminary term will commence on Wednesday, September 18, 1861, and continue until the beginning of the regular term. In addition to daily instruction in the hospital wards, and clinical lectures, at least three lectures will be given daily on subjects of practical importance, by members of the Faculty, during this term. Among the subjects which will be taken up during the preliminary term are the following:—Organic Affections of the Uterus, by Prof. Taylor; Uterine Displacements, by Professor Barker; Inflammatory Diseases of the Uterus and Appendages, by Prof. Elliot; the Thoracic Viscera, by Prof. Childs; Auscultation and Percussion, by Prof. Flint; Syphilis, by Professor Hamilton; Surgical Affections of the Genito-Urinary Apparatus, by Prof. Wood; Endosmosis and Exosmosis, with their Practical Applications, by Professor Foreman.

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The Preliminary Term for the Session of 1861-2, will commence on MONDAY, SEPTEMBER 23, and continue four weeks, until the opening of the Regular Term in October.

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University of New York Medical

Department. Session, 1861-2.

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NEW YORK, September 28, 1862.

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References—Editors American Medical Times; Jno. E. White, Esq., Warden of Bellevue Hospital, N. Y.; Prof. B. Silliman, Jr., New Haven.

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Original Lectures.

LECTURES ON AUSCULTATION, PERCUSSION, ETC.

DELIVERED AT THE

BELLEVUE HOSPITAL MEDICAL COLLEGE, DURING THE
PRELIMINARY TERM.

SESSION OF 1861-62.

By AUSTIN FLINT, M.D.,

PROFESSOR OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

LECTURE III. PART I.

Recapitulation of Subjects of preceding Lecture.—Application of Percussion to the Diagnosis of Pulmonary Tuberculosis. Examination of a Series of Cases in which the Deposit of Tubercle was abundant.—Examination of a Case in which the Tuberculous Deposit was small.

GENTLEMEN:—In my last lecture I considered percussion as applied to the diagnosis of emphysema and pneumo-hydrothorax; of affections giving rise to liquid in the pleural sac, viz. ordinary pleurisy, empyema, and hydrothorax; of pneumonia, together with other affections involving solidification of lung and intra-thoracic tumors, leaving the subject of tuberculous disease for subsequent consideration. I considered, also, the application of percussion, in a negative point of view, to the diagnosis of certain affections which do not give rise to signs obtained by this method. These affections are, bronchitis in its ordinary form, and the variety called capillary, asthma, pleurodynia, intercostal neuralgia, and various laryngeal affections. The application of percussion to the diagnosis of these affections is of great practical importance, since it enables us to exclude other affections with which they would be liable to be confounded were we dependent on symptoms alone.

I shall now proceed to consider the application of percussion to the diagnosis of pulmonary tuberculosis. And, with reference to physical signs, it is convenient to arrange cases of tuberculosis into three groups, as follows:—*First*, Cases in which the deposit of tubercle is abundant; by the term abundant, I mean a quantity sufficient to furnish well-marked, obvious signs. The quantity is abundant in by far the greater number of the cases of the disease which present themselves in practice, no matter how early patients come under our observation, after the symptoms of pulmonary disease have first declared themselves. The diagnosis, in these cases, by means of the symptoms and signs, involves usually little or no difficulty. *Second*, Cases in which the quantity of tuberculous deposit is small. It is in cases only in which the deposit is in small, disseminated masses, that much difficulty arises from the fact that the signs are not sufficiently well marked. Fortunately, as regards diagnosis, although unfortunately for the patients affected with this disease, this second group of cases embraces but a small proportion. *Third*, Cases in which the disease is advanced. I mean by this, that the disease has advanced to the formation of cavities in the lungs. The signs peculiar to this group of cases are those which denote cavities. We shall see that this classification of cases is convenient with reference to the signs obtained by auscultation as well as percussion.

What are the signs obtained by percussion when a deposit of tubercle has taken place? They are not the same in all cases. As a rule, there is diminished resonance, or dullness, over the tuberculous deposit. But exceptions to this rule are not very infrequent. The resonance may not be diminished, and it may even be exaggerated, although a considerable amount of tubercle has been deposited. But the resonance in these exceptional cases is always changed in character; it is either tympanitic or vesiculo-tympanitic resonance. We may have tympanitic resonance over a portion of lung completely solidified by tubercle, the amount

of sonorousness not being less than in health. It is easy enough to distinguish this from the normal resonance, by the absence of the vesicular quality of sound, and the elevation of pitch. Again, we may have a vesiculo-tympanitic resonance, the intensity not diminished. This occurs when, as is not infrequent, more or less of the pulmonary lobules in proximity to the tuberculous deposit become emphysematous; and, also, when the relations of the deposit to the bronchial tubes and walls of the chest are such as to give rise to a tympanitic resonance of considerable intensity, which is combined with the vesicular resonance yielded by the healthy lobules in proximity to the deposit. We recognise the vesiculo-tympanitic resonance readily by the deficiency of the vesicular quality of sound, and the elevation of pitch. Bear in mind, then, gentlemen, that, although dullness is generally produced by a tuberculous deposit, this is not an invariable rule, but that, by percussing over a deposit, a resonance is sometimes produced equal to, or exceeding, that of health; as regards intensity, the resonance, however, in these cases, being always either purely tympanitic or vesiculo-tympanitic in character.

Suppose, in percussing the chest of a patient, we find dullness, are we to infer therefrom that tubercle exists? Certainly not. Dullness, as we have seen, is due to various other pathological conditions, existing in pneumonia, oedema, pleurisy, etc. If, however, we take into account the situation and the extent of the dullness, and connect with it certain diagnostic symptoms, percussion alone is often nearly, or even quite, adequate to a positive diagnosis. It is a well-known law of pulmonary tuberculosis that the deposit takes place first at or near the summit of the lung on one side, and subsequently it occurs in the same situation in the opposite lung. The deposit very rarely extends over the whole of the upper lobe so as to solidify the lobe as pneumonia does. The dullness, therefore, is more or less circumscribed, as well as greater or less in degree. Now, if a patient present himself to us for examination, and we find dullness on percussion within a certain space at the summit of the chest; and if the history and symptoms in the case point to tubercle, we should be pretty safe in basing our diagnosis upon the evidence afforded by percussion alone, although we should never fail, under these circumstances, to avail ourselves of the additional information afforded by auscultation and other methods of examination.

I shall now proceed to illustrate the application of percussion in cases of tuberculosis. And for this purpose I have selected out of about fifty cases of the disease in my wards, six patients whom I shall examine before you. I have selected these patients at random from among those who are best able to appear in the amphitheatre. And here let me remark that you will be struck by the fact that most of these patients do not present in the countenance or general appearance, evidence of serious disease. They are not much emaciated, and their aspects are not notably morbid. You will find this to be true of certain cases. There is sometimes so little appearance of disease that you could hardly be persuaded of the existence of tubercle, were it not for the physical signs. Another fact may be here mentioned: the general appearance of disease and the symptoms are often not in proportion to the amount of tuberculous deposit as determined by the physical signs.

I now percuss the chest at the summit on the two sides successively in the patient before you. You perceive an evident disparity. There is dullness at the left summit in front, in what is called the infra-clavicular region. Observe, the sonorousness is less on that side; the vesicular quality is less marked, and the pitch is raised, the latter changes being invariable whenever dullness exists. Now, this patient has a chronic cough; he has lost weight, and hemoptysis has occurred. In view of these diagnostic events, finding, as we do, dullness over a circumscribed space, we would be safe in saying that a deposit of tubercle exists, without seeking for other signs which, however, we ought not to disregard.

Let me illustrate in this, and the other cases, two modes of percussing, in order to determine whether the deposit of tubercle be situated near the superficies of the lung or deep in its substance. The two modes are called deep and superficial percussion; in other words, deep is strong, and superficial is light percussion. If I strike lightly, the blow does not elicit sound, except from the lung substance near the thoracic walls; the blow does not, as it were, penetrate deeply. If the deposit be near the surface, a disparity on percussing the two sides will be evident, but if the deposit be deeply situated, and not large, a disparity may not be made apparent by this mode of percussing. In the latter case, a strong blow is requisite; the sound being brought out from a greater depth, a disparity is marked. In this way it is generally easy to determine whether the deposit be near the surface of the lung at the point where the percussion is made, or situated deeply. I percuss the two sides lightly in this patient, and the disparity is slight. I percuss strongly, and the disparity is much more marked. Hence, I conclude the deposit, in this case, to be deeply situated.

Another point of inquiry is this:—Is the deposit limited to, or more abundant, at the anterior or posterior portion of the lung? I settle this question by percussing in front and behind, on the two sides, and comparing the results. Here let me say, that in the examinations of the chest, in cases of tuberculosis, the scapular regions are very important. I wish to impress this the more, because the late Dr. Swett, in his able work on diseases of the chest, declared that percussion over the scapula was of little value. So far from this being true, it will often be found that the evidence of a deposit of tubercle over the scapula is more marked than on the anterior surface. It is true that over the scapula the vesicular quality of the sound on percussion is not so appreciable as in front, but it is quite as easy to make a comparison between the two sides as regards intensity and pitch of sound. I now percuss this patient over the two scapulae, above and below the spinous ridge. In this case, although dulness is evident on the left side, it is less marked than in front. The conclusion, therefore, is, the deposit is greater at the anterior than at the posterior portion of the lung on the left side.

Let me illustrate in this case, as I shall also in the other cases, a mode of percussing which I find often valuable. I place the fingers of my left hand, from behind forward, between the shoulder and the neck, grasping the part firmly, and percuss so that the blows fall directly on the top of the lung. A disparity is frequently in this way rendered more apparent than by percussing below this situation, either in front or behind. You perceive this is true in the case now before you.

Lastly, I percuss at the base of the chest, behind, and you perceive the resonance is intense, vesicular, and equal on the two sides. This should never be omitted in examining with reference to tuberculosis, for, in this way, you determine that dulness, if it exist, is limited to the summit, and you exclude certain conditions, especially pleuritic effusion, which would modify the resonance at the summit.

I now introduce another patient. Here we have relative dulness at the right summit in front. You will recollect the resonance in health is somewhat less at the right than at the left summit, but the disparity is sufficient, in this case, to warrant at once the conclusion that it is abnormal. In this case the dulness is more marked on superficial or light, than on deep or strong percussion, hence, the deposit is near the surface. It is here also more marked in front than behind; hence the deposit is greater anteriorly than posteriorly. Percussing between the neck and shoulders the disparity is evident, but less marked than in the preceding case.

Introducing another patient, we find dulness in this case more marked over the scapula than in front on the left side. This case will serve to illustrate the importance of making percussion at the summit behind.

In another patient we find a disparity at the summit, in

front, on the left side, but, as regards intensity of sound, the disparity is extremely slight; in other words, there is but little dulness. You perceive, however, that the sound is vesiculo-tympanic. In such a case as this, the evidence afforded by auscultation, of the existence of solidification, is more important than in a case in which the dulness is more marked.

In another case we have an illustration of a condition which you will occasionally find, viz. in front there is relative dulness on one side, and behind relative dulness exists on the opposite side. The explanation of this is, the deposit occurred either anteriorly or posteriorly, we will say anteriorly, first on one side, and before the deposit had extended much to the posterior surface of the same side it took place in the opposite lung—in the latter being situated at the posterior portion.*

The patient, whom I now introduce, has a small deposit of tubercle. The signs obtained by percussion, and other methods, are less marked than in the cases already examined, in which the quantity of tubercle is abundant. Cases in which the deposit is as small as in the patient before you, are not common. In the majority of cases of tuberculosis, the amount of deposit is sufficient to give rise to well-marked signs. It is only in cases of small deposit that the diagnosis is attended with difficulty. With due knowledge and care, however, in these cases, the existence of the deposit can generally be determined. I percuss the chest of this patient in front, at the summit, and on the two sides. If you observe closely, you will perceive a disparity in the resonance between the two sides. There is not much diminution in sonorousness on the left side, but the vesicular quality of the resonance is less, and the pitch higher than on the right side. I percuss repeatedly and as evenly as possible, in all respects, on the two sides; the disparity, although slight, is manifest on each percussion, showing that it is not produced by a difference in the mode of percussing. I percuss over the lower part of the chest, in front, to ascertain that the stomach is not distended with gas; for, when this is the case, the character of the resonance over the whole of the left anterior surface of the chest may be somewhat modified. I also examine the chest, in front and behind, with the eye, and satisfy myself that it is symmetrical. The resonance, then, in this case, at the left summit, is less intense, less vesicular, and higher in pitch than at the right summit. Now, is this evidence of tuberculosis? Very strongly so; indeed, taken in connexion with the history and symptoms, the evidence is almost or quite conclusive. It is much more so than if the slight dulness were on the right side, because, normally, the right side is slightly dull on percussion as compared with the left side, and, therefore, the normal disparity is reversed in this case.

In cases of small deposit of tubercle, it is important to take cognizance of the normal disparity just alluded to. This disparity, in certain cases, embarrasses us, viz. in cases in which the question is whether a deposit exists on the right side. We find a certain amount of dulness at the right summit, and we have to decide whether this dulness exceeds the limits of a normal disparity. To decide this point requires an exercise of judgment which is acquired by experience, and we call to our aid the information obtained by other methods of examination. But if we find the relative dulness at the left summit, then the normal disparity existing between the two sides is of advantage to us; we know that this dulness must denote a morbid condition, since it is the reverse of what obtains in health.

In cases of small deposit of tubercle, we should percuss with care on the top of the chest, as I have already illustrated, and as I now do in this case. You perceive that the disparity is more apparent than in front. Percussion over the scapulae is important, recollecting that dulness is sometimes more marked here than in front. Both deep and

* Other cases were examined, and these cases, exclusive of the first one, more fully than appears in this report of the lecture. In order to avoid repetitions, which are less desirable in a published lecture than in a lecture as given, when they relate to demonstrations, the several points illustrated by the different cases are here only mentioned.

superficial percussion are to be employed. In short, the object is to ascertain whether, on either side, the sonorousness is diminished or the resonance vesiculo-tympanic. And if found to be so on the left side, it is undoubtedly an abnormal sign; but if it be found so on the right side it is a question whether the disparity be, or be not, greater than may belong to health.

Original Communications.

DIPHTHERIA.

By EZRA M. HUNT,

NEW JERSEY.

ALTHOUGH much has been written upon this disease, yet in its present type it is so new in our country and its prognosis is so critical, that carefully noted facts are still needed, if, perchance, they may throw some additional light upon it.

There are physiological and mechanical reasons, why affections involving the throat always call for careful discrimination and astute attention. The two grand channels, the one of nutrition, and the other of respiration, are at once endangered, and sense and experience, no less than science, teach us the importance of sensitive watchfulness. Disease here is not only often formidable of itself by impeding deglutition or breathing, but inflammatory action is quite readily transmitted to other organs, and thus serious complications occur. Scarlatina here often shows its greatest malignancy, and under the common names of black-tongue, putrid sore-throat, and malignant quinsy, enough of unfortunate interest has been thrown about throat affections as almost to invest them with the consideration due a leading speciality. But the source of anxiety, and the duty of searching scrutiny, are sadly multiplied in the symptoms and history of diphtheria. Call it idiopathic or symptomatic, the Egyptian disease, or croup diphtherite, ally it to pleuro-pneumonia, to sub-acute inflammation, or to any of the class of maladies in which there is unhealthy fibrinous exudation, yet with all the different theories there is no difference of opinion in respect to its formidable character. Many a physician, not used to blundering, has been outstripped by the unlooked-for rapidity of its crisis, and not a few of those, old in experience as well as years, have, in its start, and in their first cases, mistaken the seriousness of the case in hand. Once recognised as the sequelæ of measles, scarlatina, or some bronchial trouble, it has now plainly established itself as more frequently an independent disease having its own distinct history, and not only plainly shows itself as an epidemic, but seems quite likely to take its permanent place in the regular catalogue of general mortality. In a brief way, without aiming at the theory, or the literature of the complaint, I propose to furnish a few practical facts such as experience, reading, and thought may have suggested.

It is by having plain matter-of-fact descriptions of disease, as it appears in different localities, that we are to form a general estimate of its character. This is the more important because diphtheria is not specially a city disease. Reports from small country towns and rural districts are not so apt to be furnished as by the well-organized societies of cities, and hence a longer time is needed before we can settle down to firm convictions as to treatment. In Middlesex Co., of this state, the disease has not prevailed to a very large extent, and yet in certain localities, sufficient to excite much alarm amongst the people, and to attract the decided attention of our physicians. On our eastern border it appeared both last winter and winter before last, but chiefly as a sequelæ to scarlatina and measles, which were there epidemic, and, although fatal in many cases, attracted no great attention as a distinct disease. In the vicinity of Elizabeth city, although the aggregate of cases was not

large, it was marked by a high rate of mortality. In New Brunswick, there have been a number of cases, but these mostly in its suburbs and not assuming a decided epidemic form. Through the intermediate country there have been quite a number of scattered cases which by their severity or suddenness have attracted general and medical notice. Along with these, there have been a great number of throat affections of a milder character. We have been called upon to look into more throats than during many previous years of practice, and while some were imaginary troubles, yet a large number have shown a diffused redness differing from bronchitis or any of the usual irritations of the palate or tonsils, yet mild and readily yielding to the use of chlorate of potash, alum, and slight counter-irritation. Whether these bear the same relation to diphtheria that scarlatina simplex does to the maligna, I cannot determine. In the few specimen cases I have selected for remark, I have, however, excluded all these and confine myself to such as I feel fully justified in terming diphtheria. In order to present several facts in brief compass, a thing always desirable in medical communication, I subjoin the following table so far as it goes:—

Case 3d had no treatment except for quinsy.

Case 1 and 6 occurred in the practice of my co-laborer, Dr. M. The one that seemed much benefited by the local application of the nitrate of silver.

CASE.	AGE.	RESULT.	PROGRESS OF DISEASE WHEN FIRST SEEN.	AVERAGE DURATION OF DISEASE.
1. girl.	4 years.	Died.	1 week.	4 weeks.
2. girl.	18 "	Died.	5 days.	7 days.
3. boy.	21 "	Died.	Moribund.	7 days.
4. boy.	7 "	Recovered.	Seen early.	2 weeks.
5. girl.	5 "	Died.	5 days.	3 w'ts (relapse).
6. boy.	8 "	Recovered.	Seen early.	2 weeks.
7. girl.	18 "	Recovered.	Seen early.	6 days.
8. boy.	15 "	Died.	4 days.	18 days.
9. girl.	10 "	Recovered.	Seen early.	7 days.
10. boy.	17 "	"	"	17 days.
11. girl.	17 "	"	"	4 days.
12. boy.	16 "	"	"	10 days.

Cases 2, 3, 5, were mistaken by the parents for slight quinsy, and therefore not much attended to.

As to temperament, those of scrofulous diathesis most speedily succumbed, but among those dying were two of apparently excellent constitutions.

Of those dying, none went to bed voluntarily except to die. They felt more comfortable sitting up, and showed but little alarm at their condition. • Decided restlessness in one or two cases, almost like that of mild delirium tremens, was noticeable.

The attack on each case was with chilliness and fever, and in some, but not in all cases, vomiting. There was convulsion in but one case and that slight.

The mode of death was precisely the same in each case, anemia. Each one had no perceptible pulse at the wrist several hours before death.

The fatal symptom was a sudden change of the pulse from its frequent, quick, nervous beat, to a tired slow one, and then after a few hours death.

Every case seen in two days after attack recovered; those not seen until four days or after, all died.

Of all the cases save one, an unstrung, spiteful, frequent, irritable pulse was characterized. In those that recovered, the change from this was usually gradual but marked. In one case, a boy of 17 (No. 10), the pulse was throughout preternaturally slow. In one case the throat was not badly affected, but the deposit was chiefly in the mouth and sides of the cheek. This was a young lady who was a constant watcher over a sister sick with the disease.

Swelling of the glands about the throat was a prominent symptom in most of the fatal cases.

Those cases seemed to do best in which the upper portion of the throat and the nasal organs were involved, more

in proportion than the laryngeal or pharyngeal portion. The condition of the bowels and that of the urine, were not such as to call for any special medication. In each case there was some difficulty of deglutition, but this not as decided as one might be led to suppose. Absence of appetite, and in one or two fatal cases, loathing of food, were accompanying circumstances. All were as well supported as possible, and case No. 8 took, by mouth and injection, a good amount of nourishment up to the very last. Although the pulse in each case denoted feebleness and nervous irritability, yet acts did not show great weariness. Vomiting of food was in one fatal case a distressing symptom throughout the disease, digestive power seeming to be suspended thereby. Difficulty of breathing was an occasional but not prominent symptom. In two or three cases recovery was protracted, the patient seeming very slowly to regain strength and energy.

Bearing on contagion, are the following points:—Case No. 1, was a child who had been on a visit where the disease prevailed at a distance of a few miles. No other children in the family, however, contracted the disease.

Cases No. 3 and 4, occurred in two different families where these were the only children, and both had been visited, between two and three weeks previously, by a lady who had fled from Staten Island on account of a very malignant type of the affection in the family with which she resided. She complained of sore throat while on the visit, but not serious. An older member of one of the families had, after the other cases, a deposit of false membrane on one tonsil, but it speedily yielded to a single cauterization.

Cases 5, 6, 7, and 13, occurred in one family in succession among those most exposed, and one or two other members suffered from the kind of sore-throat above referred to. Several others, however, who were exposed, escaped. The school was disbanded for two weeks, and case No. 13 was seized upon return but immediately removed. Cases 8 and 9 both occurred in another family, but a third child was not affected.

The general plan of treatment was as follows: Nitrate of silver applied with the *porte caustique*, or in a strong solution by means of a large camel's hair pencil chiefly along the sides of the patches of membrane. After this is fully formed and so abundant as not to be within reach, I believe caustic to be of little value. Dr. Abernethy, of Rahway, told me over a year since, after seeing much of the disease as a sequela of measles or scarlatina, that he always succeeded in checking the local trouble when he could thus keep in advance of the exudation, and such has been my experience. In some cases it has been reproduced, but not so freely or tenaciously as at first.

Externally counter-irritation was used with salt pork—pork and pepper, or turpentine, according to age, the design being to cause pretty speedily a slight eruption.

In cases where there were incipient signs of diphtheria I used opium and *acetas plumbi* as a gargle, and mild nitrate of silver solution, being directed by the same rules that would guide me in their choice for the mucous membrane of the eyelids, at the same time giving chlorate of potash internally. What these cases would have been in the absence of such treatment I know not, but I thought in them, as well as in one or two decided cases, I derived advantage from their use. I used Labarraque's solution somewhat, but believe it valuable only when there is much fetor.

But the chief reliance is the constitutional treatment. Tonics, stimulants, and antiseptics, are surely demanded in the disease. The chlorine mixture used with judgment is among our best remedies. In some cases the chlorate of potash will agree better alone than with the hypochloric acid. I have never seen the disease which, as a rule, will so well bear the use of quinine, citrate of iron and quinine, wine whey, and the best of food. Yet a routine treatment of the malady is greatly to be deplored. It has some variety in type and symptoms, and is to be carefully watched and readily treated. In general, the nervous sys-

tem is prominently involved, and the disease acts like a powerful depressant poison thereupon. Yet in the robust it often commences with fever of an inflammatory type. Case No. 12 was taken the most severely of any I saw. I gave over night a free purge of calomel and chlorate of potash, and ipecacuanha every three hours, until the next day at noon. A single dose of quinine, three grs., was then administered, followed by a Dover's powder at night to control extreme restlessness. The subsequent treatment was the chlorine mixture, wine whey, quinine, and an occasional Dover's powder. I believe opium indicated where there is much restlessness in the early part of the attack; the nervous thrill of the pulse, the appearance of the tongue, and the sleepless nights, justify their judicious use. Among the many excellent articles on the disease which your good journal has furnished us, none has satisfied me better than that of Dr. Kneeland.

One or two brief suggestions and I have done.

1st. If the general theory as to the disease is correct, we ought to be able to do something by means of prophylactics. Is it not well to use the chlorate of potash for children in every family in which the disease appears to enjoin regularity in eating and a good diet. The more I have seen of the ailment, the more has my confidence grown in the treatment if commenced in season; and there is reason to believe that a bad state of the solids exists somewhat previous to the local manifestation in the throat. The very fact of taking something as a preventive has a valuable control over mental excitement, and the chlorate of potash, being itself a tonic, is no less a safe than an efficient remedy.

2d. I have used muriate of ammonia somewhat in the disease, but have not definite facts enough to recommend it, but I beg leave to refer to it as worthy of trial. Many eminent German physicians have valued it highly as an alternative, and they at least would suggest it as thus valuable in this disease. It combines an expectorant, a stimulant, an antiseptic, and I have long attached much value to it in the treatment of throat affections, both as a local and general stimulant and alternative. Others who have thus employed it have confirmed its value. I notice that Dr. Kneeland refers to it as a valuable component in a gargle for this disease, but I believe it also highly useful in its constitutional action. There are a few other points as to pathology and hypothetical treatment, to which I might allude, but as my design was only to speak of practical facts and experience, I leave those for more extended testing and research. The disease is one still *sub judice*, and even the small fractions of facts may aid in arriving at more settled conclusions as to treatment.

AN ACCOUNT OF THE DISEASE OF COUNT CAVOUR.

TRANSLATED FROM THE FRENCH.

By DR. P. F. C. DESLANDES.

THE sudden death of Count Cavour has not only been a great public event, but, in a medical point of view, particularly in England, the subject of very severe criticisms, which it might perhaps have been more proper not to publish before having received sufficient information. Having received on this subject a detailed and reliable account, the editor of *L'Union Médicale* presents it in his paper under the form of a clinical case.

M. de C., *âgé* fifty-one, of middle size, had a large head, a short neck, broad shoulders, and was of a lymphatico-sanguine temperament. He slept little (four or five hours in the twenty-four), ate much, and followed, as to diet, the custom of England, where he had lived in his youth. For eleven years he worked fifteen hours a day. His occupations were incessant, and had been particularly so for the last two years. Except very slight attacks of gout, to which he was subject, and, six years ago, an intermittent

fever, which he had much trouble to get rid of, never had he experienced any serious or long disease.

For about one year he had been complaining of very sharp colics, coming on at night usually, and which he treated by one or two bleedings. He was almost entirely his own doctor, putting little confidence in physicians generally, although he consulted them when he was sick. The physician who had attended him from his childhood had been dead two years, and was replaced by Dr. R., a man of merit, but who had not enough influence over the mind of his illustrious patient.

About the 15th of May, Mr. de C. having spent three days on one of his estates at Léri, near Vercell, a border country, exposed himself to the great heat of the sun in going through the fields. On his return to Turin, he was observed not to be so well as usual, and to be more irritable. On the 20th of May, after having dined with appetite, and without having presented anything peculiar in the evening, he was again seized with colic. He sent for his physician, and he was bled. The next day, 30th, the fever being intense, it was thought necessary to bleed him again twice. The night was calm, the sleep quiet. On the morning of the 31st, the apyrexia was complete. Mr. de C., thinking himself cured, acted accordingly. Contrary to the advice of Dr. R., he received many persons during the day, and dispatched a good deal of urgent business. He had kept his bed. The following night (that of the 31st of May), a new attack came on with reaction towards the brain. The abdomen was painless on pressure. At the request of the patient, bloodletting was again resorted to; and he was bled twice. The night of the 1st to the morning of the 2d, he was almost sleepless. An injection was prescribed, and, in anticipation of a future exacerbation, the following prescription was given: Fifteen grains of citrate of quinine in twelve pills, two pills every two hours. At 10 o'clock P.M., the fever returned, but was preceded, this time, by chills which lasted one hour. It continued during the night, and the next day, June the 3d, at noon, it had not yet disappeared. A consultation with Dr. Maffani was appointed for 5 o'clock. The patient was delirious, and insisted on being bled. Bloodletting was practised for the sixth time at 4 o'clock, one hour before the consultation. The blood was without a buffy coat, rich in fibrine, and very plastic. At 5 o'clock the head was scarcely warm; the physiognomy was natural; the delirium had ceased; the tongue was moist; the skin good; the pulse full but soft, and the fever moderate. Nothing abnormal in the chest or abdomen. Urine rather muddy. At 10 o'clock the apyrexia was almost complete. 15 grains of citrate of quinine were taken in three doses, at 11, at 3, and at 6 o'clock. The calm did not last long. At 2 o'clock A.M., on the 4th, another paroxysm supervened, with cold stage, which lasted one hour; then heat, with delirium, agitation, a burning head, and diarrhoea. At 7 o'clock the symptoms were not quite so intense. The patient answered questions; but left to himself, he immediately became delirious. The same dose of citrate of quinine was prescribed, together with cold applications to the head, and synapisms to the legs. At noon the fever had decreased, the apyrexia was almost complete.

At 8 o'clock there was a new paroxysm; the delirium of the same kind as before; ran on all the subjects which habitually engaged the attention of the patient. He still answered correctly any questions, said he did not suffer, but often carried his hand to his head, which was very hot. The paroxysm lasted all night. A draught composed of distilled water of lettuce, distilled water of oleander, and syrup of diacodium was given.

On the morning of the 5th, at seven o'clock, the fever was less intense, the pulse fuller. The urine rather abundant, with a slight deposit. Prescription: Citrate of quinine, xv. grs., acetate of morphia, two-fifths grs. To take in four doses. At noon the pulsations of the heart were obscure, and the pulse hardly perceptible at the left wrist. Four cups were applied at the nape of the neck, and there seemed to be a little improvement. At six o'clock there was

a change for the worse, yet he was still conscious at times. At eleven o'clock he recognised the King. At two o'clock on the morning of the 6th, the body was covered with a cold sweat; the radial artery was no longer to be felt. The delirium was constant. Political men and affairs passed and repassed without order before the eyes of the patient. Mr. Farini had watched at his bedside. At three o'clock he gave him the papers destined for the King. At half-past four o'clock all consciousness had disappeared. At a quarter to seven o'clock a little rattle was heard: ten minutes after Mr. De C. was no more.

The above is the correct account of the symptoms of the disease, and the means used in its treatment. Now what was the disease? The beginning had been insidious, and might, as it did, on account of the precedents of the patient, give rise to doubts. However, we perceive from the administration of the citrate of quinine, that already, before the consultation with Dr. Maffani, the family physician had diagnosed an intermittent fever. This learned physician shared this conviction, since the antiperiodic agent was used until the last moments.

If we review the symptoms we can more or less clearly distinguish fine paroxysms of unequal duration and separated by unequal intervals. The first during the night of the 29th to the 30th of May; the second, in that of the 31st of May to the 1st of June; the third, in the evening of the 2d. As to the two others, one would have occurred in the night of the 3d to the 4th, at two o'clock in the morning, and the other in the evening of the same day, at eight o'clock.

In this hypothesis, certainly very plausible, of an intermittent fever of a malignant type, many questions arise. The result was fatal, notwithstanding the repeated use of the febrifuges. Could they have been employed too late, and in too small doses? Could not the repeated bloodletting at such short intervals have diminished their effect? These repeated bleedings have struck our minds with astonishment. Mr. De C. was robust and in the habit of being bled. On this point we could only venture assertions. We will say, however, that when the access was very strong, bloodletting was observed to increase the intensity of the periodical concentrations.

As to the other question, every one knows that malignant intermittent fevers cannot be too soon attacked. A few days' delay may have thus influenced the result. Many physicians affirm that when treated in time and energetically, the success is almost certain; whilst others, having an experience equally great of these affections, declare the prognosis to be always very grave. Could these differences of opinion depend on the difference of locality and latitude where each one has practised? Again, the difficulties which the diagnosis presents are sometimes very great. If, as in some epidemics, the symptoms presented only an exaggeration of the usual stages of the febrile paroxysm, the error could be generally avoided. But these attacks are not only malignant, but sometimes marked by other morbid forms, by the *Fièvre muqueuse ataxique* of Pinel, for example, which, according to our confrère, Dr. Cerise, seemed to have characterised Mr. De C.'s disease.

One remark and I have done. Does the citrate of quinine, in equal doses, possess the same action as the sulphate, much better known and oftener used among us?

THE RHODE ISLAND MEDICAL SOCIETY.—The first quarterly meeting was held at the "Franklin Society Rooms," Providence, on Wednesday, the 2d inst., at 10 o'clock A.M. The society was called to order as usual, by Dr. C. W. Parsons, the President; and in the absence of the Recording Secretary as surgeon in one of the R. I. regiments, Dr. Homer Batchelder, M.D., of Cranston, was elected Secretary *pro tem*. The Society passed a resolution to appoint and send delegates to other State Medical Societies; and Dr. Edwin M. Snow was elected a delegate to attend the annual meeting of the Vermont Medical Society, to be held on the 23d inst.

Reports of Societies.

NEW YORK PATHOLOGICAL SOCIETY.

Stated Meeting, Sept. 25th, 1861.

Dr. A. C. Post, President, in the Chair.

EXTENSIVE REPRODUCTION OF BONE.

Dr. SANDS presented two specimens of tibiae which illustrated in rather a remarkable manner the reproductive power of bone. The specimens were sent him by Dr. W. J. Almon, of Halifax, who also furnished the following history:—

"The boy died suddenly a few days ago of serous effusion into the ventricles of the brain. I send you the bones of both legs, in order that you may compare their relative length, and the size of the two fibulas. The patient, aged twelve years, was an inmate of the Halifax Poor Asylum, of a pale complexion and scrofulous habit with necrosis of the tibia; the dead bone showing itself about an inch below the tuberosity of the tibia, and at other points to about two inches above the ankle-joint. There was constant discharge from the leg, hectic fever, and other constitutional symptoms. Several months after he had been admitted into the Asylum I made up my mind to remove the necrosed bone. After I had commenced the operation, I found the dead and new bone so intimately connected, and my patient's strength sinking, I then thought that it was best to remove the whole bone, which I accomplished by sawing it through just below the tuberosity, and about two inches above the malleolus, and dissecting out the bone. There was but little hemorrhage, and notwithstanding a rather severe attack of smallpox, which set in a short time after the operation, the wound healed by granulation. For the last few months the boy has been learning the trade of a shoemaker, and has walked about with the aid of a crutch, and when not watched, without it."

On close inspection of the specimen but two points were seen where the bone had failed in its reproductive efforts, and one of these was about an inch above the internal malleolus, and the other about an inch and a half above the middle of the shaft. From the superior articular surface of the tibia to a distance of six inches there is a continuous formation of bone. Although the amount of bone reproduced was very considerable, Dr. Sands still regarded the specimen as illustrating the truth of the conclusions arrived at by the German experimenters, viz. that in cases where the periosteum was left there the reproduction was most perfect; but where the periosteum was removed there the effort at restoration was very imperfect. He did not think that in the case under consideration the reproduction would have been any more complete.

CARTILAGES WITHIN THE SHEATH OF THE TENDON.

Dr. Post presented several specimens of cartilage which he removed from the theca of the flexor tendon of the middle finger of the left hand of a patient, aged twenty-five. The tumor was about the size of an ordinary nutmeg, and was situated at the junction of the first phalanx with the palm of the hand, was hard to the feel, and lobulated, and moved slightly on the subjacent parts. Instead of one cartilaginous tumor, as was expected to be found, there were several. Two, considerably larger than the others, lay within the synovial cavity, and upon the surface of the tendon of the flexor sublimis; others were found attached to the fringed edges of the synovial membrane, and portions of these were lying upon the surface of the flexor sublimis; others were found between the flexor sublimis tendon and that of the profundus; while others were beneath the profundus. Dr. Post stated that it was the only instance that he had met with in which cartilages were found within the sheath of the tendon.

MELANOTIC DISEASE OF EYE.

Dr. Post also exhibited a specimen of melanotic disease of the eye which was removed from a young woman in New Jersey, about a week before. The cavities of the eye were found filled with the diseased deposit, and there was besides a mass of considerable size which surrounded the globe of the eye; yet between these two there existed no communication, the coats of the eye being uninvolved. There was a considerable amount of oedema of the subconjunctival tissue, forming a considerable tumor which covered the lower part of the eyeball.

TONSIL REMOVED BY ECRASEUR.

An enlarged tonsil was also shown which was removed by the wire *écraseur*. He thought that the advantage of the instrument in such cases was, that a larger portion of the tonsil could be grasped than by the guillotine. The operation occupied but a short time, and seemed to occasion very little pain.

The Society then adjourned.

NEW YORK MEDICAL AND SURGICAL SOCIETY.

The interest manifested in the reports last year of the discussion on diphtheria from this society has induced us to offer in a condensed form the instructive medical and surgical cases that have been presented by the different members during the last year or two. In order to make such matter as attractive as possible the cases will be, as far as practicable, arranged in groups irrespective of the order or time of presentation.

PERITONITIS.

Perforation of Appendix Vermiformis.

CASE I. Pelvic Abscess simulating Enlargement of Bladder.—Dr. BUCK was called to see a lad, 16 years of age, who was thought to be suffering from distension of the bladder. There existed in the region of the bladder a fluctuating tumor reaching upwards within two inches of the umbilicus, and easily recognised through the rectum. The urine passed freely, however, and the catheter after having been introduced could not be readily moved about. Pain was complained of in the lower part of the belly; pulse 130; no rigor and no fever. The case was a very perplexing one, but Dr. Buck decided to puncture the tumor through the rectum. The operation resulted in the evacuation of nearly two quarts of purulent fluid, the swelling of the abdomen at the same time disappearing. The patient lived a little more than a week afterwards, death being preceded by vomiting, diarrhoea, and occasional hiccup. On post-mortem examination the great omentum was found adherent to the pubes and the small intestines adherent to one another, and to the brim of the pelvis; thus forming the superior boundary of a pelvic abscess, which occupied precisely the situation of the bladder in a state of distension. The bladder itself was small and contracted.

CASE II. Probable Perforation of Appendix Vermiformis—Peritonitis—Recovery of Patient.—Discharge of Blood and Pus from the Bladder during Convalescence.—Dr. CLARK related the following case of peritonitis, probably depending on perforation of the appendix vermiformis. The patient, aged 14, was a son of a medical friend, and was first seen by Dr. Clark on the 25th of March, in consultation with Drs. Smith and Buck. The chief symptoms at this time were pain, and great tenderness in the right iliac region; the pulse was not much accelerated, and there was no tympanitis. Hopes were entertained that the disease would not prove serious, and a full dose of opium, together with an enema, was administered. On the following morning, the patient seemed comfortable, but towards evening he grew worse, and showed evident signs of general peritonitis. The pain and tenderness, however, were still most intense in the right iliac region. Opium was now regularly

administered, and its use continued throughout the subsequent progress of the case. The drug was given chiefly in the form of laudanum, and the largest amount administered on April 3, when the patient took grs. 1350. These large doses removed the pain, and induced sleep, but the intellect was not at all affected. The disease was attended with several remissions and exacerbations, and each time, as the severity of the symptoms declined the dose of opium was diminished, to be again increased in proportion to the violence of the disease. The case exhibited several unusual features, one of which was an inability to empty the bladder, without the assistance of the catheter. This symptom appeared soon after the supervention of general peritonitis. Another remarkable symptom was diuresis, which, for the most part, presented an intensity directly proportioned to the amount of opium administered. Thus on April 3, when the maximum quantity of laudanum was given, there were voided 136 oz. of urine, the largest amount passed during any period of twenty-four hours. The case was also complicated with diffuse inflammation in the parotid region, which appeared on the sixth day, and resembled the swelling seen in typhoid fever. Suppuration, which at one time seemed inevitable, did not occur, and the swelling, after a time, disappeared. At this stage of the disease calomel was added to the opium, and given in doses of gr. ij every two hours. At the end of thirty-six hours its use was discontinued. The last peculiarity in the case was noticed at the beginning of convalescence; it consisted in the discharge of a little pus and blood from the urethra during the evacuation of the bladder, and was first observed in the urine last voided. The presence of these morbid products in the urine lasted for several days, and their passage was attended with severe pain in the glans penis. Perforation of the bladder was suspected, but the occurrence of this accident was not rendered certain by any further evidence. The subsequent progress of the case was towards recovery. There yet remained, however, an irregular hardness in the right iliac region, also tenderness and considerable pain when the patient made any sudden or incautious movement of the body. In conclusion Dr. Clark expressed the opinion that the case should be regarded as one of perforation of the vermiform appendix, that had yielded to only moderate doses of opium.

DR. WATSON inquired whether any member of the Society had ever known of a sub-peritoneal abscess opening into the bladder.

DR. CLARK recollected the case of a young lady having the symptoms of an abscess above the bladder, and directed towards the right iliac fossa. The abscess opened into the bladder, as was indicated by the sudden discharge of turbid and extremely fetid urine, and coincident subsidence of the tumor.

DR. DALTON remarked that he had once made an autopsy where he discovered a tuberculous abscess that had burst into the bladder. Pus was noticed in the urine ten days before death. After death it was found that although pus had passed from the abscess into the bladder, the urine had not passed into the abscess.

CASE III. *Perforating Ulcer of Stomach, and probably Passage of Renal Calculus—Peritonitis—Death.*—DR. CLARK related the following case: Some months ago I saw a gentleman who had been suffering a long time with the most formidable symptoms of dyspepsia. He was unable to take any kind of food, as he believed, without great distress. He vomited frequently, and lost flesh, so that he was very thin. Still he kept about his business to a certain extent, being able to go down town every second or third day. His physician had tried every kind of food, as he thought, that might serve his stomach, but seemingly to no purpose. The patient would occasionally vomit with his food little shreds of black matter, and it occurred to the physician that it would be better to give all the food cold. This did very well for a couple of days. He was sitting in his office about three o'clock in the afternoon reading a newspaper, when he was rather suddenly seized with severe

pain which, at five o'clock, was described as being in the course of the ureter. The abdominal muscles at that time were as rigid as they could be made. I asked him if the testicle of that side was retracted, and he said rather impatiently that he believed it was. This pain continued with marked severity, and was only diminished by the administration of large doses of opium. His pulse from this time up to three A.M. the next day was steadily below 80, but there were present not the least traces of tympanitic distension, and no pain except on this one side. At three o'clock in the morning of the second day, i. e. thirty-six hours from the time of the attack, he had a very marked change in his symptoms. A message was sent to the physician and me, and when we arrived there we found the patient exceedingly prostrated. He had had what was then thought to be a fainting fit; he was perspiring pretty freely, and his friends thought he was dying. From that time the pain became more general, and by breakfast-time it extended over the whole abdomen. There was then some slight relaxation of the abdominal muscles, and some little tumefaction. About noon of that day he died.

A partial post-mortem examination was allowed, so partial that we were not permitted to satisfy ourselves in relation to one point of interest in the case. The first thing that struck us in opening the abdomen was a moderate amount of peritonitis. Believing this due to a perforation of the stomach we looked there, and discovered just near the pylorus one of those ulcers, which is, so to speak, walled up to a certain height, penetrating to the peritoneum, and apparently forced through, seeming more like a tear than anything else. We then imprudently announced that the immediate cause of death was perforation of the coats of the stomach. This being done we were not allowed to go further, and so had no opportunity of ascertaining whether or not a calculus existed in the ureter. My own view of the case was, that the pain of the first day was owing to the passage of a calculus down the ureter, and that this extraordinary tension of the walls of the abdomen, in some paroxysmal movement of the stomach, had caused rupture of the ulcer and peritonitis, and I still entertain that opinion. Dr. Detmold, who was present at the time of the autopsy, thought, inasmuch as the ureter, when cut across, was not reddened, that there was no calculus. There were no traces of cancerous degeneration about the organ.

I never saw in any person nearly so firm a contraction of the abdominal muscles that lasted so long. The striking thing about it was that the pulse did not go above 80 for thirty-six hours after the first attack, and was 120 a little after breakfast. When I saw him again it was 130, and it continued up to some high number during the few remaining hours that he lived. Then too after that came the relaxation of these exceedingly tense muscles.

CASE IV. *Puerperal Peritonitis, etc.*—DR. CLARK had lately (April 1860) seen four cases of peritonitis, three of them after childbirth, and one the result of metritis; all of which have been successfully treated. The peritonitis in each case was treated by full doses of opium to produce the sensible effects of the drug; and in the case of metritis by leeching, veratrum viride, and a moderate amount of opium afterwards. One of these cases is perhaps worthy to place on record to see if there are others that are parallel with it. A young married lady of Brooklyn, a patient of Dr. Mitchell, attended a funeral on Sunday, two weeks to-morrow, of a young lady who died of metro-peritonitis. The post-mortem examination was made, and the funeral took place soon after. In the evening the lady referred to was seized with a chill, with a moderate amount of pain in the pelvic region, which pain, in the course of the next day, extended over the abdomen, and was attended with some tympanitis. Dr. Mitchell made the diagnosis of metro-peritonitis. At the time I saw the case the Dr. had been treating her with opium pretty freely, and with a good result. She has been convalescing now for more than a week. I should remark that she was not menstruating on Sunday, but that was the day that the menstrual flux should have returned.

It has occurred to me twice before (if this case be admitted to belong to that class) to see persons attacked thus during the menstrual period, and while they were attending upon puerperal fever. One of these occurred in private practice, the other in Bellevue. In one instance the patient was an unmarried lady, and in the other was a widow who had no children for several years before. In conclusion Dr. C. stated that there had been a similar case in St. Vincent's Hospital, under the observation of Dr. Finnell, and that Dr. Parker had also met with such a one a couple of years before.

Dr. WATSON knew of two cases that terminated fatally.

Dr. BLAKEMAN stated that there had been a case reported within the last ten years in Bellevue Hospital where metropertinitis was caused in a menstruating female by attendance upon another.

Dr. METCALFE stated that he had seen a great deal of puerperal peritonitis, and did not recollect one instance where a nurse had been attacked. It was fair to suppose also that some of the nurses out of this number were menstruating at the time. If the disease under those circumstances was contagious, more than one case would have occurred in Bellevue Hospital in ten years.

Dr. PARKER next related the following case: He was called in consultation by Dr. Mitchell, of Brooklyn, to see a young unmarried lady, about twenty-four years of age. The patient, a few years ago, had suffered from an attack of what was supposed to be inflammation of the pelvic peritoneum. She recovered from this, however, and went on enjoying tolerable health until within a month ago, when she was seized with the same set of symptoms as before. The inflammatory stage was passed through safely, and she began to convalesce.

On the morning of the tenth day, while turning over in her bed to reach something, she was suddenly seized with an intense pain in her abdomen, followed very soon after by great tenderness on pressure.

Dr. Mitchell was immediately sent for; on his arrival found her suffering very intensely, and late in the evening of that day Dr. Parker was sent for. When Dr. P. arrived she was suffering from all the symptoms of general peritoneal inflammation in a marked degree. Her pulse was 120, and there was some vomiting and hiccough present. It was evident from the history of the case that the inflammation was the result of the escape of some matter into the peritoneal cavity; but where that matter came from it was impossible to determine, inasmuch as there had existed no symptoms previously that pointed to trouble with the vermiform process.

Dr. Parker saw the patient in the afternoon of the next day, and she died at six or seven o'clock the next morning. At the last visit she seemed tolerably comfortable, her pulse was below 100, but still the vomiting and hiccough continued. The result of the autopsy showed the existence of peritoneal inflammation of the pelvic cavity, but more especially of the omentum, the meshes of which were matted together by the effusion of false membrane. The omentum also contained several abscesses, and it was the bursting of one of these that caused the relapse. Before Dr. P. saw the patient she had taken some *verat. viride*, together with anodyne injections to allay the pain. Under the influence of both these remedies the pulse remained about the same in frequency, 130, but the respiration decreased from 20 to 8 per minute. The use of both the remedies was then suspended for twelve hours, when the respiration came up to 20 as before, the pulse remaining unchanged. Thinking that the opium might affect the respiration, the *verat. viride* was used alone in doses of four or five drops, when the respiration again dropped to 8 per minute, while the pulse was the same in frequency as before. In conclusion, Dr. Parker remarked that he had never met with a case where the administration of the *veratrum viride* was attended with any such results.

Progress of Medical Science.

PREPARED BY DR. DESLANDES.

Discussion on Glanders.—The Academy of Medicine, of Paris, has lately been engaged in a discussion on glanders, in which Messrs. Bouley of Alfort, J. Guérin, and Tardieu have taken a prominent part. The whole of this discussion ran on the following questions put by Mr. Guérin: Cannot glanders exist in diverse and progressive degrees? If incurable in the last stage, has it not passed, before reaching it, through different phases in which it was curable? What are the causes which lead it to that ultimate and fatal stage? Lastly, What are the means by which it might be prevented from reaching that degree of incurability?

The remarks of the learned and witty professor of Alfort in answer to these questions are thus summed up by the editor of *L'Union Médicale*.

I. The competency of Mr. J. Guérin, as regards glanders, is questionable. II. Mr. Guérin fancied he saw cures where there were no cures. III. Mr. Guérin knows not that the slightest external symptoms of glanders indicate, to practised eyes, the most formidable internal lesions of the disease. IV. The clinical observation of glanders, with which Mr. Guérin is not familiar, demonstrates every day that these pretended diverse degrees of the disease do not correspond with the intensity of the general infection, and for those who know how to discern it, glanders exists already where there is to be found but the most superficial erosion under the ala nasi of a horse.

After Mr. Bouley has pronounced glanders incurable, it will not be without interest to read the two following cases translated from the *Gazette des Hôpitaux*:

Case I.—In April, 1859, writes Dr. Joufflet of Montrouge, I bought a thorough-bred mare, 7 years old, and apparently sound. One month after: pustules in the legs ulcerating; subcutaneous abscess, glands, œdema of the limbs. I took the mare in that condition to Alfort, where Mr. Reynal diagnosed chronic glanders requiring slaughtering. No running at the nose, nothing there nor in the pharynx or the mouth.

I could not consent to such a sacrifice. Having informed my groom of the necessary precautions to be taken, I instituted a treatment. 75 grains of sulphur, twice a day, common salt, iodine, good diet. The subcutaneous abscess opened of itself; a degenerated ganglion formed an enormous vegetation. I removed it, and to combat suppuration I administered the fresh leaves of aconite; the animal was losing flesh. I continued this treatment for four months, aided by good diet: barley, wheat, oats; and to-day my mare looks so well, that I am beset by amateurs who want to buy her.

Case II.—One of my friends, adds our confrère, having a horse in the same condition, was going to have it slaughtered, as it did not eat. It was placed under the same treatment (injections, tincture of iodine, and sulphur at meals). After a few days the appetite returned, and with it the strength, etc.

Case III.—I have read, says Dr. Lesur in a letter to the editor of the *Gazette des Hôpitaux*, not without a lively interest, in your number of the 26th of June, a case of cure of glanders. A similar case having been met with by me in my practice, I consider it my duty to mention it to you.

Two farmers, father and son, contracted glanders from five horses affected with it. The father fell rapidly a victim to acute glanders. The son, whose disease assumed the chronic form, was placed under a mercurial treatment: calomel internally, cauterization of the pustules with the acid nitrate of mercury.

One month after the cure was complete, and there has been no relapse now for twelve years.

Nutrition of Bones.—Mr. Cl. Bernard presents to the

Academy of Medicine, in the name of Mr. Alphonse Milne-Edwards, the exposition of some experiments on the nutrition of bones.

Since the beautiful experiments of Chossat, we know that animals require for the continuance of their life, to inject every day into their stomach, besides alimentary substances properly so called, a certain quantity of mineral matter. This skilful experimenter proved that if this quantity of mineral matters come to fail the bones become thin and fragile, and the animal dies after a shorter or longer time. How does this destruction of the osseous tissue take place? Is it by resorption of the calcareous matter or by the entire disappearance of this tissue, cartilaginous matter and animal matter at the same time? This question, which Chossat did not try to solve by chemical analysis, Mr. Alphonse Milne-Edwards, son of the eminent Professor and President of the Academy of Sciences, has just endeavored to answer.

For that he had only to deprive for some time an animal of calcareous salts, then to find out by chemical analysis whether, under the influence of this diet, the bone had become poorer in inorganic matter, or whether its volume alone had diminished without any change in the relation of the elements to each other.

Mr. O. Milne-Edwards experimented on pigeons which he fed on wheat, rice, Indian corn, and decorticated millet-seed. At the end of three months of this diet, these animals were taken with diarrhoea and began to fail. The volume of their bones was much smaller than usual, they had lost about one-third of their weight. As to their composition, it had never changed, although they had been deprived of calcareous salts; hence we must conclude that it is not only the earthy matter which has been abstracted, but that there has been a resorption of the osseous tissue itself. These experiments confirm the opinion, that the osseous tissue is the result of a chemical combination of the organic matter with the phosphate of lime.

Regeneration of Bones.—Mr. Hamel read before the Academy a series of cases of regeneration of bones. Of the five cases I come to submit to the appreciation of the Academy, four, said he, are mine. The periosteum, as formative and regenerating organ of the osseous tissue, has obliterated a large perforation of the frontal bone, reproduced the right half of the lower jaw, the greater portion of an ulna, a portion of the body of a femur, lastly, almost the whole of a tibia.

At the time when osseous regeneration seemed a dream, although it had been the object that led Mr. Flourens to his researches on the periosteum, a man, 36 years of age, came to consult me for a perforation of long standing, near the left frontal eminence. The hole was nearly circular, large enough to pass the thumb through it, but thickset with asperities. There existed, as a consequence of this, a hernia of a portion of the brain and of the dura-mater. I advised him to apply permanently a piece of leather on the hole. Several years elapsed, the hernia at last completely disappeared. I had lost sight of the man, although we lived in the same city, when I was requested by the civil authorities to certify to his death—he had died from superficial cerebral hemorrhage, the result of a violent blow with the fist received in a fight. I remembered his old infirmity, and examined carefully the cranial cavity. To my great surprise, I found a whitish periosteal membrane of new formation, uneven, rather thick, of a cartilaginous appearance, applied on the dura-mater to which it adhered towards its centre. It was situated in front of the frontal perforation, whose rounded shape it had, and from which it must have been abruptly detached. The gradual but entire occlusion, the only admissible cause of the complete disappearance of the cerebral hernia, could not be but the result of a slow and reparative process. How it did take place would be difficult to explain. However it be, nature has shown, in this circumstance, how far her resources and her generative power can go.

In the second case (a necrosis of almost the whole of the left lower maxillary bone), the restorative power of the

periosteum became apparent from the moment that the work of insulation was ended. The necrosed bone was entirely reproduced, the teeth only were wanting. The angle of the jaw remained less projecting, more receding; it gained in width and thickness what it lost in height.

A short time after this cure, a muleteer, 28 years of age, came to me with the left forearm rather painful and twice the natural size. In the middle of a suppurating wound, seventeen and a half inches in length (fifteen centimètres), stood half bare the necrosed body of the ulna. A fall from a horse, violent enough to produce at first an enormous and painful swelling, had induced a fistulous abscess about the lower third of the ulna, where its denudation took place. When I probed the ulcer, it was red, hard, and granulous. Although very extensive already, the two extremities of the bone were not visible. As it was movable at one point, I sawed it with a small, convex, watchmaker's saw, then with the circular saw of the trephine. The lower fragment detached itself a few days after, breaking in two. The fall of the upper fragment took place only three weeks later. On examining the internal surface of the periosteum, rugose and bleeding, I perceived that this membrane had become three times thicker and had acquired a strong consistency. Three months had hardly elapsed, when the patient, notwithstanding an imperfect cicatrization, used his forearm, whose volume was still larger than that of the other. The shape of the new ulna, where regeneration had taken place for a length of nine inches (eighteen centimètres), varied also in some parts. This twofold osseous reproduction is so much more remarkable that it took place in a country, the habitual hygienic conditions of which were very unfavorable to this reparative process.

Pierre Ravult, 14 years old, fell from a horse in April, 1859. This was soon followed by a deep fistulous abscess along the internal part of the right leg. At the end of nine months a fistulous tract left bare the necrosed tibia, and the first ulcer healed. When he came to consult me, in August, 1860, his leg was in a frightful condition, it had doubled in volume. The anterior portion was occupied by a deep ulcer with everted edges. The principal bone necrosed to the extent of ten and a half inches (twelve centimètres), was prominent in its middle, isolated from the soft parts, and saturated with a fetid and abundant pus.

The preservation seemed to me at first an utopia. I flinched at first, however, at the idea of amputating. After mature reflection I decided on waiting. The strength of the patient, instead of failing, had improved. To a vast local suppuration, disinfected by chlorine, was opposed an assimilation sufficient to replace the everyday losses. I favored it by the use of barks, wine, and ferruginous drinks, cod-liver oil, with iodine and a reparative animal diet. Under such conditions, and always preoccupied with an idea which, as it seemed to me, could be realized, I resolved on cutting, with the saw, on the projecting part of the denuded bone, as far as the medullary canal, and dividing it in three parts. I was in hope to render the fragments more movable, and to insulate them sooner from the periosteum, the reparative work of which I was afraid they might retard. The natural irritability of the subject, the capricious irregularity of the digestive organs, the too often repeated capillary hemorrhages, arrested my efforts, and answered but imperfectly the end I had proposed to myself. However, after the fall of two thick fragments, situated at the opposite extremities, the body of the tibia detached itself in its turn from its two articular epiphyses. From that time, January, 1861, the reparative process, long begun, pursued its progressive march; the osseous wool spread soft and spongy as it became more solid. I discovered no trace of a new medullary canal. I could study the metamorphoses which the new bone underwent until its entire development, as much in its aspect, its color, the saturation of its tissue, its gradual thickening, as in its greater force of consistency, always increasing, and more marked than before. There truly is revealed to the eyes of the observer the important part which nature has assigned to the periosteum.

American Medical Times.

SATURDAY, OCTOBER 19, 1861.

QUININE AS A PROPHYLACTIC.

THAT quinine is a prophylactic against malarious diseases is an established medical as well as popular opinion in many regions of our own country. The same belief obtains in other portions where malaria prevails to any great extent, and still practitioners who have little or no malarious diseases in their vicinity are quite ignorant of this fact. The Sanitary Commission has just issued an interesting circular recommending to the surgeons of the army quinine as a prophylactic against malarious diseases. The report is drawn up by Dr. WM. H. VAN BUREN, of this city, who has had opportunities of testing the quinine; and as the facts which he presents, confirming the value of this agent, are of general interest to the profession, we shall notice them briefly. In many parts of the South and West the prophylactic employment of quinine is common by planters, for themselves, their families, their overseers, and negroes. Quinine is also used in our merchant-service, on the Isthmus of Panama, and in vessels trading with other unhealthy ports, to prevent attacks of fever. The President of the Panama Railroad Company, DAVID HOADLEY, Esq., furnished the Chairman the following interesting statement: His attention having been called, in 1853, to the unusual amount of sickness which prevailed among the crews of vessels visiting Aspinwall, he was led to investigate the matter, and came to the conclusion that the regular habitual use of quinine by the crews, for a few days prior to the arrival of the vessels at that port, while in port, and subsequent to their departure, would remedy this evil. Accordingly, by the advice of a physician, he recommended the employment of wine and quinine made into a palatable mixture and called "wine bitters." This preparation was immediately placed on board of every vessel of the line, with directions for its use. The result we give in his own language:

"The result of this course exceeded our most sanguine expectations. From its very commencement a change for the better was seen, and during the last four years, in which seven vessels have been constantly employed in the trade, cases of sickness have rarely occurred—certainly not one case in ten, as compared with former times. The practice of using quinine, as above stated, is continued to the present day, and so uniformly healthy are the crews of our vessels that the subject no longer excites our solicitude. I would also remark that the use of quinine by the officers and employees of the company on the Isthmus has been found very beneficial, and in connexion with this, and the clearing and settlement of the adjacent country, Aspinwall has become one of the healthiest tropical ports of which I have any knowledge."

PROF. G. B. WOOD, of Philadelphia, says:—"There is no prophylactic measure against the miasmatic fevers at all comparable in efficiency to the use of this medicine." Dr. DE SAUSSURE, of Charleston, South Carolina, believes that he has collected "a sufficient number of data to render the opinion plausible, if not conclusive, that quinine possesses power of protecting the white man from attack of intermittent and remittent fever, or its collaterals, when exposed

for even long periods to malarious influences;" and he adds, "that its daily use is in no wise injurious to health, nor does its habitual use render the system insusceptible of its remedial powers." He mentions the following striking examples which came under his notice:—

"An overseer agreed to take charge of several rice plantations in one of the sickliest regions of rice culture, undertaking to spend the summer months on one of the plantations. He made no inquiry as to the health of the one chosen as his residence—it was selected from its convenient locality. When warned of the danger of his residing there in summer, he said he would never have the fever. His confidence in his capacity to resist malarious disease seemed unlimited. The result fully justified this confidence. He lived ten years or more in that neighborhood, spending every summer on the plantation, varied only by an occasional visit to the healthy pine land, where his family resided during the summer. He visited his rice fields without hesitation at any hour, day or night, that his business required. He never had an attack of fever during that time. I saw him after he had been there several years; a finer specimen of robust health it would have been difficult to find. It was ascertained on inquiry, that it was his habit to take quinine daily, during the summer, before leaving his house; the quantity he did not know, for he never weighed it."

"He was called in August to see one of the contractors on the Charleston and Savannah Railroad, laboring under a very severe attack of remittent fever, contracted during the superintendence of his contract between the Ashepoo and Combahee rivers, notoriously a very unhealthy region. During his convalescence he informed me that he would have to return to his work on the road, where he had a large number of hands employed (150); that they were negroes brought from healthy regions in North Carolina, and he expected all of them to be more or less sick, as they were entirely unaccustomed to a malarious climate. I advised him to take quinine daily himself, and to give it to all his hands, white or black. Late in the fall I met him in the city; he looked healthy and well. He thanked me for the advice I had given him; told me he had carried up some pounds of quinine; had used it himself daily, and compelled all his employees to take it also; that he himself had never had another attack of fever; that his health was better than it had ever been, and that not a single one of the 150 hands he employed had been attacked by fever. In fact, he said: 'The only case of sickness I have had was in a negro who had come from North Carolina sick.'"

DR. VAN BUREN alludes to his own experience while on the medical staff of the U. S. Army in Florida. A serious outbreak of miasmatic disease occurred at the station, and the stock of quinine being exhausted, a substitute was prepared with whiskey, the bark of the common dogwood, wild cherry bark, and a small quantity of quinine, which reduced the number of relapses, and mitigated the attacks.

The British naval authorities have long been impressed with these facts, and have acted accordingly. Dr. BRYSON states in the Navy Medical Reports (No. xv.) that—

"It has long been a standing rule in the Navy, enjoined by the 9th Article of the Surgeon's Instructions, that when men are to be sent on shore in tropical climates, to procure wood and water, or on other laborious duties, the surgeon, if he consider it advisable, is to recommend for each man, previously to his leaving the ship, in the morning, a drachm of powdered bark (Peruvian), in half a gill of wine, and the like quantity of wine after the mixture; or, if there be no wine on board, one-eighth of a gill of spirits, mixed with the fourth of a gill of water, is to be used in lieu of it; and the same proportion of each is to be given to the men on their return to the ship in the evening."

The British Army has been similarly provided, and the medical officers directed to employ quinine as a prophylactic. During the war of the Crimea, the Medical Director of the Army wrote as follows to the Inspector General of Hospitals:—

"With reference to previous letters on the subject of administering quinine, and other preparations of bark, as prophylactic remedies, I have the honor again to draw your attention to the matter. From all I have learnt I am persuaded that the number of cases of fever would be diminished by such a course. So convinced am I, especially by the results of the experience of naval medical officers, of the benefits arising from the prevention plan, when followed in localities in which remittent and intermittent fevers are likely to prevail, that I have taken care to provide ample supplies of quinine in anticipation of every possible demand for that article. Having now at command sufficient of this drug, specially provided for that service, to furnish five grains per diem to every member of a force of 35,000 men, I beg you will take such measures as you think proper, with a view to induce the medical officers to employ that remedy, in the hope that it may prove useful in warding off attacks of fever, etc."

During the preparations for hostilities in China, in 1859, the Director-General issued the following order:—"That a stock of quinine wine be provided, in order that a ration of it be given to the men previous to and during the unhealthy months, or when the soldiers are required to proceed up the rivers, or on being encamped in the vicinity of marshy ground. A medical officer should be present when the quinine wine is issued, and to witness the same being drunk by the men."

The committee continue their quotations at length from medical writers and travellers, showing conclusively that quinine is the great prophylactic as well as curative agent in malarious diseases. The importance of this circular at this critical period in the history of our volunteer army can scarcely be over-estimated. The great majority of the surgeons of these forces have been little accustomed to the treatment of malarious diseases. The season has arrived when the progress of the war is to transfer large bodies of troops directly into regions where malaria exists now in the most concentrated form. Unless some prophylactic is employed, these malarious fevers will decimate our susceptible army in six months, and render it impotent against an acclimated foe. Happy it is in our power to shield those who go bravely forth to meet the exigencies of war, from one of those consuming forces which threaten the Northern soldier in his progress Southward, viz. malarious diseases. We cannot sufficiently commend the Sanitary Commission for its prompt recognition of the medical necessities of our troops, and the distinguished Chairman for the admirable and convincing manner in which he has presented this subject to the consideration of our authorities and the surgeons of the Army and Navy.

THE WEEK.

The recent Army Order, in which the Medical Director of the forces on the Potomac recommends that "Pirogoff's operation at the ankle-joint should be preferred to Chopart's, or to amputation above the ankle, in cases that might admit of a choice," has excited much interest among surgeons, and no little inquiry as to the relative merits of these operations. Pirogoff's operation is but little known in this country, having been performed too infrequently to give

any reliable results. Indeed, the question has been so frequently asked—What is Pirogoff's operation? and it is so meagrely described in current surgical works, that we are induced to quote the description of the several steps as we find them given by the author himself in an English publication. It is as follows:—

"I commence my incision close in front of the outer malleolus, carry it vertically downwards to the sole of the foot, then transversely across the sole, and lastly obliquely upwards to the inner malleolus, where I terminate it a couple of lines anterior to the malleolus. Thus all the soft parts are divided at once quite down to the os calcis. I now connect the outer and inner extremity of this first incision by a second semilunar incision, the convexity of which looks forward, carried a few lines anterior to the tibio-tarsal articulation. I cut through all the soft parts at once down to the bones, and then proceed to open the joint from the front, cutting through the lateral ligaments, and thus exarticulate the head of the astragalus. I now place a small narrow amputation saw obliquely upon the os calcis behind the astragalus, exactly upon the sustentaculum tali, and saw through the os calcis, so that the saw passes into the first incision through the soft parts. Saw carefully, or the anterior surface of the tendo achillis, which is only covered by a layer of fat and a thin fibrous sheath, might be injured. I separate the short anterior flap from the two malleoli, and saw through them at the same time close to their base. I turn this flap forwards, and bring the cut surface of the os calcis in apposition with the articular surface of the tibia. If the latter be diseased it is sometimes necessary also to saw off from it a thin slice with the malleoli."

It will be seen that Pirogoff's operation originally consisted in dividing the os calcis at right angles to its long diameter, and applying the cut surface to the articular face of the tibia, the malleoli being removed. More recently it has been slightly modified in various ways, as removing the articular surface of the tibia, dividing the os calcis obliquely from above downwards and forwards, etc. It will be seen that Pirogoff's operation is, in fact, the operation for ununited bones, the two cut surfaces being placed together for the purpose of obtaining union.

Such is Pirogoff's operation. Now, as to its absolute and relative merits, the author himself thus sums them up:—

"1. The tendo achillis is not divided, and so we avoid all the disadvantages connected with its injury. 2. It also follows that the base of the posterior flap is not thinner than its apex, while the skin on the base of the flap remains ununited with the fibrous sheath of the tendo achillis. 3. The posterior flap is not cap-like, as in Syme's method, and its form is therefore less favorable to a collection of pus. 4. The leg after my operation appears an inch and a half (sometimes even more) longer than in the three other operations (Syme, Baudens, Roux), because the remnant of the os calcis left in the flap, as it unites with the inferior extremities of the tibia and fibula, lengthens them by an inch and a half, and, 5. Serves the patient as the point of support."

Much has been written for and against this operation. Several of the early cases were represented as terminating unfavorably by the death of the remaining portion of the os calcis, and its final separation. At one period, it was alleged that its projector had himself abandoned it. Recently, however, the statistics of the operation have been collated, and they give a more favorable impression of its value. Its mortality is fixed at about fifteen per centum, the rapidity of the cure equals that of other amputations, and the resulting limb is undeniably the best that can be obtained for direct use.

An English Bishop has determined to examine all candidates for holy orders who appear before him to prove their fitness for church duties by reading or preaching in his presence. The *Lancet* suggests that this examination should take place before the candidate commences his studies, and that there be added to the examiners medical men of experience and judgment.

"In such a probationary examination as we suggest, the importance of medical scrutiny must be obvious. There is many a short-breathing, weak-voiced clergyman now getting through his Sunday services by great exertion, who only needed early counsel and proper training to render him capable of bearing easily a far heavier strain upon his physical powers. The 'clergyman's sore throat,' which medical men know so well, is almost always attributable to ignorance of the proper method of using the voice. It is unknown amongst actors, and rarely affects really eloquent preachers and speakers, because they recognise the importance of obtaining proper and intelligent control over the instrument by which they display their power. In the case of any candidate rejected under the new test proposed by the Bishop of Rochester, we cannot but think that, on the present system, he has been subjected to a most flagrant injustice. His years have been wasted, his money spent, and his best energies taxed to the utmost—all in vain, because no means were taken to gauge his capabilities before he began his fruitless labors."

The following sketch of the dwellings of the poor in Dublin by MR. NUGENT KENNEDY, has its parallel in New York:—

"Out of a population of 249,000, 50,000 at least reside in a fetid and poisonous atmosphere. The dwellings of the poor are chiefly confined to about four hundred and fifty lanes, courts and alleys, and about sixty streets. The entrance to most of these courts is very narrow—a sort of great stenchvalve or overground sewer. As a general rule, there is a green slimy stream oozing from a surcharged and choked-up cesspool, through which the visitor is compelled to wade: the stench from this ooze is intolerable. In a tottering house, in an alley like this, the deformed offspring of a narrow street, the working man is forced to dwell. If he is unable to pay two shillings a week in a street, he must live in a court or alley for ninepence or a shilling. A large number of the houses set in tenements are three stories high. In many of them, the stairs are so crazy as almost to render it unsafe to go up or down. The yard accommodation is atrocious. In some districts, where the houses are built in blocks, there is none whatever. Some of the cottage tenements are, if possible, more unhealthy than the houses; the ceilings are lower, and the light wretched. In many instances I found the boards rotted away, and the inmates sleeping on the damp ground."

The Surgical Section commences its session on Friday evening next at the residence of the Chairman, DR. JAMES R. WOOD. The regular meetings will be held on the third Friday evening of each month. This Section was one of our most active Societies during the past year, its meetings being largely attended, and its discussions of the most practical character. The subject of Diseases of the Joints and their Treatment was most thoroughly discussed by this society, and a large amount of material collected for a future report. New subjects of great interest to the practical surgeon will be brought forward during the coming winter session. The invitations are widely extended to the profession, and many practitioners from other cities and the country, temporarily in the city, have passed a pleasant and profitable evening at the meetings of this Section, to which they are always heartily welcomed by its hospitable Chairman.

The anticipated early movement of the Army of the Potomac, excites great anxiety on the part of the medical profession of the States with reference to the preparations of the medical department for the pressure that may be made upon it. GEN. McCLELLAN has indicated his desire for enlarged hospital accommodations, and the time is evidently near at hand when a different, larger, and better class of hospital provisions should be provided for the Army of the Potomac.

Reviews.

ON THE ORIGIN OF SPECIES BY MEANS OF ORGANIC AFFINITY. By H. FREKE, A.B., M.B., M.D. T.C.D., M.R.I.A., Fellow of King and Queen's College of Physicians in Ireland, etc., etc. "Nothing is advanced in this publication that is not perfectly in harmony with the Mosaic record of Creation."—Preface. London: Longman, & Co., Paternoster Row. 1861.

"Dust thou art and to dust shalt thou return." This is the law. The author of this remarkable little treatise gives us the formula. We had prepared an abstract of the argument, following the author's arrangement, for our readers, but both on account of its unavoidable length, and because we think that by altering that arrangement we can present his views more concisely, and at the same time more clearly, we have concluded to substitute a condensed general view.

The work consists very largely of extracts from former writings of the author, contributions to the Dublin Medical Press, and a work on Organization, and does not, therefore, present the same regular sequence that it would do if entirely written as a whole.

We may divide the objects of the treatise into two: First, an inquiry into the present ultimate constitution of organic matter; and second, a deduction from this as to its origin. Its fundamental idea is that the ultimate molecules of organic life, animal or vegetable, visible under the microscope, and known to physiologists as cytoblasts, cell-germs, etc., are physiologically indivisible, and are therefore properly to be called organic atoms, holding the same relation to the organic world that the theoretical atoms of inorganic nature sustain to matter at large. "As chemical affinities exist between the latter, so, it is claimed, organic affinities exist between the former. So that we have the same right to expect that the result of these affinities will be to produce a symmetrical living being in the one case as a regular crystal in the other. Our readers will recognise in this idea the analogy so carefully elaborated by Schwann in his chapter on the "Theory of Cells," in which he ably maintains the *Physical* in opposition to the *Teleological* view of development. The function of these atoms is to elevate matter in the scale of organization, while, at the same time, they reproduce a plurality of like atoms. They are, therefore styled, and we like the designation very much, "Organizing Atoms." The matter which they have thus elevated in the scale of organization, is termed "The organized Residual Product" of each species of atom. We have examples of them in lignin or woody fibre, and albumen in the vegetable, and in fibrine in the animal. These "Residual Products" act as the nutriment, or as he prefers to call it, the "specific stimulus," of the organizing atoms next in order above them, without which stimulus they will not perform their function. Thus we have a regular series, the lowest species of organizing atoms finding their stimulus in inorganic or mineral matter, upon which they confer the lowest degree of organization, thus not only repeating themselves, but producing the stimulus for the next higher species, and so on, until we arrive at a point, both in the vegetable and animal, where resident products are elaborated, above which there are no organizing atoms. What then is the function

of these highly organized products? In the vegetable creation they subserve the uses of the animal creation. In the latter, their function is to manifest the phenomena of animal life. And now follows a very subtle and beautiful distinction between vegetable and animal life. The author supposes the function of the atom to be exerted, by radiating its organic force upon the surrounding matter, just as a heated body radiates its caloric; and as a fluid, placed in a solid freezing mixture, parts with its caloric, and itself becomes solid, while the freezing mixture, on the contrary, becomes fluid, so he conceives the atom to part with its organic vitality while it converts the matter around it into an organized cell, or elevates it to its own level. In conferring life the atom itself dies. This process goes on in both animal and vegetable. In both, the atoms die in childbirth. The residual products, however, in the vegetable kingdom do not thus die; they are stored away, year after year, or fall beneath the laws of chemical disintegration. Not so in the animal. Here the residual product finds its noble function in evidencing the phenomena of animal life, motion, sensation, thought, and in its discharge, likewise dies. Thus in the vegetable we have *organic* life at the expense of *atomic* death; in the animal, *organic* life at the expense of *atomic* death also, but, in addition, *animal* life at the expense of *productual* death. All life, therefore depends upon death. Not only are we made to feel with the Apostle, that "In the midst of life we are in death," but going a step further, we must admit that the moment we cease to die, in that moment do we cease to live.

We think that we have thus put our readers in possession of the author's opinions, with regard to the present constitution of organic life. We shall now reproduce, as briefly as possible, his views as to its origin founded upon them. We have a right to suppose, in fact we know, that, in the organic, as in the inorganic world, the number of species of atoms is comparatively few. We have, for instance the muscular atom, the vascular atom, the nervous atom, etc. Now these typical atoms being few, and the residual products being likewise few—how can we account for the immense number of species in both plants and animals? Simply by the difference in the number and arrangement of the atoms, and hence of the productual tissues in the different species. These compound atoms, representing the ovule of the future individual, or the original embryonic germ of that species of animal, have been formed under the influence of organic affinities, of which we are as yet ignorant, and hence the idea of the "Origin of Species by means of Organic Affinity." Each simple atom is a living being, descended from its parent, which in like manner acknowledges an ancestry of its own species. Why should we not follow up this heraldic tree until we come to the parent trunk, which would be the first atom of that species as it came from the hand of the Creator, just as we trace the myriads of the human race back to the original pair, not, we hold, as the author has it, to a "*single Graafian vesicle*," for a single Graafian vesicle could give existence to but a single individual to provide the specific stimulus, for the compound embryonic atom provided by the first would be useless, as the author has himself shown? Organic matter then, as originally created, was simply a collection of organizing atoms or granules, few in number, one for each species, which the author conceives might, if brought together, have constituted a comparatively small granule. This granule (or granules) was "*the embryo of organic creation*," "*one parent of all since existing organic creation*," "*its other parent* being as I conceive a mineral or inorganic world."

This conclusion is substantially the same as that arrived at by Darwin, viz. that all organic creation has sprung from a single primordial cell; and the author claims, with some justice, that the fact of two investigators arriving at the same result, the one by analogy and the other by induction, and acting entirely independently each of the other, entitles that result to a very respectful consideration.

He concludes with an earnest and spirited protest against the tendency of many good men to stigmatize as infidel every scientific theory which does not fully accord with their interpretation of the revelation of scripture, and disclaims any attempt on his own part to establish a result at variance with its true interpretation. There are points in the work, with reference to the original creation of atoms, etc., which present great difficulties to our mind, and which we wish had been touched upon more fully. But the extreme interest and great ingenuity of the argument are beyond question.

A PRACTICAL TREATISE ON THE DISEASES OF THE SEXUAL ORGANS OF WOMEN. By F. W. VON SCANZONI, Professor of Midwifery and Diseases of Females, in the University of Würzburg, etc. Translated from the French of Drs. DOR and LOCIN, and annotated with the approval of the author, by AUGUSTUS K. GARDNER, A.M., M.D., Professor of Clinical Midwifery and the Diseases of Women, in the New York Medical College, etc., etc.; with upwards of Sixty Illustrations. New York: Robert M. DeWitt, Publisher. 8vo. pp. 669.

In giving to American physicians the masterly treatise by SCANZONI, done into good English, DR. GARDNER has accomplished an undertaking for which he deserves the thanks of the profession. His publisher also has done nobly in bringing out the volume in a superior style of typographical elegance, notwithstanding the disastrous times.

The volume is strictly a practical treatise on Gynecology, and in its succinct account of the pathology, symptoms, and morbid anatomy of maladies of the uterine organs, we find every form of those maladies lucidly described, and a rational therapeia suggested. The subject matter of the treatise is systematically arranged, and every question is discussed in a scientific manner, particularly as respects symptoms, pathological anatomy, and the etiology.

As most of our readers will doubtless read the book for themselves, we need not enter upon an extended analysis of contents. But we would briefly remark, that all the more frequent and important forms of uterine disorder are fully discussed, while the more rare and occult are carefully investigated in the light of the latest pathological researches. As a guide to the practitioner, and a work of philosophical merit, we heartily commend this treatise to the profession.

Correspondence.

DR. PETERS'S RENUNCIATION OF HOMŒOPATHY.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—A few words only in reply to Dr. Peters's "Vindication." I disdain all feeling of "vindictiveness," with which I am charged; there is neither cause nor motive for any such feeling on my part. Our interests do not clash in the least; and whatever may have fallen from my pen which might seem unkind, may find its true explanation in a jealous regard for the honor, dignity, and status of a noble profession. Dr. P.'s "Renunciation" would never have elicited a single remark from me had it been full, candid, and unconditional; as it was, it really seemed, and indeed was, only a *quasi* renunciation, a semi-apologetic defence of the fundamental principle of homœopathy, professing a hesitating willingness to abandon it, provided the profession would accept his apology, while it left him free to practise "either system," as interest or choice might dictate. It was against this attempt at riding two horses at the same time that I protested; while it was acknowledged that there was but one horse in the ring. I am ready, after suitable probation ("by their fruits shall ye know them"), to fraternize with any respectable homœopath, who has been regularly educated to the profession, who will satisfy me that he has fully renounced all the peculiar dogmas of the homœopathic school, and made himself sufficiently acquainted with the

recognised doctrines and principles of true medical science. As Dr. P. now states that he "is prepared to renounce *all* of *homœopathy*, except that which the regular profession has already, or may in the future adopt," I have nothing more to say, as he now stands on true scientific ground, and it remains to be seen whether he consistently and openly maintains it. If he refuses to consult with homœopaths, and repudiates the dogma "*similia*," conforming to the code of ethics of the "American Medical Association," it will be the duty of regular practitioners to recognise him as a member of the medical profession, and accord him the merit and status to which he is legitimately entitled.

CONTRARIA CONTRARIIS.

RESULTS OF TIGHT LACING.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—When we breathe we take into the chest, or inhale, and give out, or expire, a certain quantity of air, which can be measured by breathing through a curved tube into a bell glass full of water, inverted over a pneumatic tub. Dr. Herbst, of Göttingen, has lately been performing some curious experiments in relation to the quantity of air that is breathed. Now the commonest understanding will appreciate from them the value and comfort of full and unrestrained breathing. Dr. Herbst says, that a middle-sized man, twenty years old, after a natural expiration or emission of air, inspired or took in eighty cubic inches, when dressed, and one hundred and six when his tight dress was loosened. After a full dilatation of the chest, he inhaled one hundred and twenty-six cubic inches when dressed, and one hundred and eighty-six when undressed. Another young man, aged twenty-one, after a natural expiration, took in fifty while dressed, and ninety-six when undressed.

Had Dr. Herbst made his observations on some of the ladies, who carry the use of corsets to extremes, we apprehend that he would have obtained results of a nature really alarming. If the wheel of fashion which revolves even more rapidly than that of fortune itself, would but bring up something oriental in costume, it would go far towards perfecting the objects of our journal—the public health.

At the Hotel-Dieu, the great hospital at Paris, a young girl of eighteen lately presented herself to M. Breschet for his advice. On the right side of her throat, she had a tumor of variable size, but never bigger than one's fist; it reached from the collar-bone as high as the thyroid cartilage (called in common language, Adam's apple), when pressed downwards it wholly disappears, but returns as soon as the pressure is removed; it is indolent, soft, and elastic. It is observed to be largest when the chest is tightly laced in corsets. In short, by placing the ear on it, the murmur of respiration can be heard in the tumor, which proves that a protrusion of the lungs has taken place; or in other words, that this poor girl has been laced so tightly that her lungs, having no longer sufficient space in their natural situation, are squeezed out of it, and are forcing their way up along her neck.

D. J. LYSER, M.D.

BROOKLYN, N. Y., October 9th, 1861.

FOREIGN CORRESPONDENCE.

[Letter from DAVID P. SMITH, M.D.]

DUBLIN.

May 16.—Saw Mr. Wilde and Dr. Stokes. I was particularly struck with the remarks of Mr. Wilde upon the unanimity of feeling which characterized the profession in Dublin. He said that in most instances, if not all, those who had become noted for anything were supported and confirmed in their special aims by the rest of the profession, and that instead of publishing marvellous reports and questionable procedures to bring grist to the mill, there was nothing of the sort known. The profession was too honorable and too high socially to descend to any such thing.

Men uncouth in their manners and anything but pleasing, had been, for their sterling worth, placed by their professional brethren in positions of influence and affluence.

May 17.—Mr. Wilde's clinique that I visited to-day appears to be very capably conducted. I have seen no place, not even excepting the clinique of M. Sichel, that gives more facility for the study of eye and ear diseases. I saw many cases of almost entire destruction of the eyes, resulting from the Irish famine years ago. Purulent ophthalmia of young children I observed was treated by a leech at the external angle and a purge of calomel. Ulcers upon the cornea were touched by a camel's hair brush dipped in solutions of argenti nitras, five and ten grs. to the ounce. A case was shown of congenital absence of one meatus auditorius externus, the other ear being perfect. A lad of about fifteen years was brought by his father, who, supposed to be deaf and dumb, had recently evinced signs of hearing, and make attempts at speech.

May 18.—I accompanied Dr. Stokes to-day in his rounds of the Meath Hospital, and saw much to interest me, which, however, can hardly be expressed on paper. The rapidity with which Dr. Stokes seizes upon the chief points of a case, the ease with which he gives to each symptom its appropriate place and importance, his wise discretion in dealing with physical symptoms, and the readiness with which he adapts his remedies to the varying conditions and requisites, must be seen to be appreciated.

May 20.—This morning I visited the lying-in hospital now under the charge of Dr. Alfred H. McClintock, who stands very high in this city as a scientific man. In going with him around the wards of this munificent charity, I saw much reason to admire the care and tact with which he appreciated the wants of, and ministered to each case. In conversing upon puerperal fever he remarked that the opiate plan of treatment had not been successful in his hands; that he placed more reliance upon leeches than anything else, but that the disease assumed so many forms that he thought it wrong to generalize upon the treatment. I observed, however, in going the rounds that every patient that had had any considerable soreness in the abdomen had been well leeched, had taken castor oil and turpentine by way of a purge, and blue pill, digitalis, James' and Dover's powders *pro re nata*. He called my attention to several cases where pelvic cellulitis, arising from puerperal peritonitis, was slowly resolving under this treatment. He insisted upon the necessity of carefully examining the groins in every case of retarded recovery after accouchement, because the stimulants and tonics and gentle exercise, prescribed under the idea of no local lesion, made the suppuration of these pelvic intumescences certain.

The utmost care is used in this Charity to prevent infection. The beds in which the women lie-in are made of straw, in order that they may be destroyed after once using. It is found that the mental emotions have the greatest effect upon the women here confined, for, as the Master remarked, a woman will have got through her travail excellently when her aunt or sister will come in, telling the poor woman that her husband has been drinking, or some such agreeable intelligence, and then disease sets in. In fact, it has been necessary to have no one admitted, except by permission obtained in each case, and those permissions are usually restricted to the husband and mother. Mental distress has such an effect in inducing disease that it is found that those who are unhappy at home or are unmarried are the ones to take puerperal fever. Dr. McClintock's views upon mammary abscess are somewhat peculiar. He thinks it arises from irritation of the nipple more frequently than from any other cause, and is best treated by cooling evaporating lotions. I was shown a case where on the vulva there appeared to be two Hunterian chancres, but on passing the finger a little higher the great mass and induration of the disease caused one to immediately exclaim carcinoma. A case was shown me as a caution against the careless use of the tampon. The woman said that some years ago a tampon had been applied for three months with daily

changes, to check profuse hæmorrhage. Several months after that, having been admitted to this hospital on account of the continually recurring hæmorrhage, one day a clot was observed in the os uteri, which being removed was found to be formed upon a shred of cloth. Dr. Stokes called attention to the fact that you often obtained the first indication of returning health after fever from auscultation of the heart. A case was shown where pressure was being constantly made upon an abdominal aneurism by way of experiment. In a conversation with the conservator of the museum of the Royal College of Surgeons here I was told that any other treatment than that by pressure, of external aneurisms, had in Ireland been entirely given up. He showed me the cast of an aneurism of the posterior tibial, where pressure applied in the morning had, by the same evening, resulted in a cure.

May 22.—Mr. Wilde to-day performed extraction in a very masterly manner. He was most particular in his avoidance of pressure, and allowed much time to elapse between each step of the operation. He remarked that a continental surgeon, who was once present at a very protracted operation of his for extraction of a dislocated lens, after the completion of the procedure with safety to the eye, complimented him, saying that he *knew how to wait*. Two cases were then subjected to linear extraction, which a week previous had had the cataractous lenses broken up by the needle. They were easily evacuated, thus saving much time, and also the expense of keeping them in the hospital.

May 21.—This morning I heard Mr. Colles lecture at Stevens' Hospital upon disease of the knee-joint. He did not seem very favorably disposed towards resection, but seemed to think that ankylosis might be obtained by rest and careful position as well as by excision. In going the rounds of the hospital with him, I saw many cases most interesting, which my limits forbid my mentioning. At seven p.m. I went to the Lying-in Hospital to hear a lecture from Dr. McClintock. It was on the condition of a woman after delivery, and was replete with information. I was pleased that the *nervous shock* so disregarded by authors was fully noticed, and declared to have repeatedly produced death in this institution. Dr. Butcher showed me to-day some of his cases at Mercer's Hospital. One of the most interesting was that of a girl about ten years of age, from whom he had removed full six and a half inches of the whole diameter of the shaft of the left femur, before new bone had formed. Every endeavor was made to preserve the periosteum, and extension was kept up, and now the little sufferer has a serviceable limb but little shorter than normal. Another case was shown me where much necrosed and carious bone had been removed from both the upper and lower portion of the tibia. So extensive had been the removal of bone that splints were required for the solution of continuity, but the result was a perfect limb. I was present some four or five years ago at an amputation of a leg, performed on account of the utter destruction of the lower part of the tibia by this disease. Had the true nature of the affection been recognised early in this case, and free incisions made, and perhaps the bone trephined, I have no doubt the young man would have saved his limb.

May 24.—Mr. Wilde's infirmary presented to-day many cases most instructive to the observer. He mentioned the practical fact that leeches at the outer angles of the eye did not occasion the cedema always following leeches upon the under eyelid. If I have not already described a curious disease of the appendages of the eye, I will now. A patient will present himself with all the outward appearances of purulent ophthalmia, and yet, says Mr. Wilde, an abscess of the outer angle of the eyelids occasions all this, and a free opening of it relieves all the symptoms. A case of meningitis was shown me, having got nearly well under the use of the bi-chloride of mercury. Inasmuch as it followed close upon syphilitic iritis, Mr. Wilde judged it to be syphilitic.

Mr. Robt. W. Smith showed me to-day in the Richmond Surgical Hospital several very interesting cases. One was

exsection of the knee, in a female of middle age, performed four months ago. Sufficient osseous union has taken place to render the limb inflexible, but a profuse discharge is rapidly wearing the patient out. Recovery in this case is very doubtful. I was struck with the very great pains with which the professor dressed the limb, taking particular care to prevent protrusion forwards of the lower end of the femur. A case of flat foot was then shown, which was placed in an apparatus of Prof. Smith's invention, the essential part of which is a pad worked by a screw, which, the rest of the foot being firmly held, presses firmly against the os scaphoides, compelling it to occupy its proper place. Prof. Smith said that one week's wearing of the apparatus would restore the foot to its proper shape, and a few weeks' perseverance in its use accomplish a cure.

[Letter from C. Y. SWAN, M.D.]

PARIS.

Sept. 6, 1861.

As M. Maisonneuve has written but little, he is consequently but little known beyond his wards. He is now over fifty years of age, was formerly attached to the Hospital Cochin, but for the last five years has held a service in the Hospital la Pitié. His bald head is very round and large, forehead immense, eyes large and brilliant, nose turned up, mouth decidedly non-classic, chin double, and underneath a string of whiskers which come from each ear not unlike a cap strap. He is of low stature, and by the size of his abdomen is rendered somewhat ungraceful. In manners, exceedingly rough, is clear and forcible as a speaker, and as an operator, there never was one who could torture poor sick humanity with more perfect sang-froid than he. For example, who but he could smilingly circumscribe so tender an organ as the eye, with six or eight *flèches*, each cruel spike driven firmly to the orbit's base, and no anaesthesia thought of.

"Who can all sense of others' pains escape,
Is but a brute at best, in human shape."

I forgot to state in my last letter that the *flèches* were, perhaps, first introduced by a surgeon of Lyons. There is no one thing probably which better exemplifies the "progress of surgery," than the present management of fractures. With what uncouth lumbering machines the unfortunate patients used to be encased, and how bedridden they got, whereas now, the dressing is so light, strong, and safe, that the man with a broken leg walks in the garden. Our New York surgeons, though, seem not yet all to appreciate this style. They revere antiquities; and I will venture to say that there are more of the old clumsy fracture apparatus, now used in the three New York Hospitals, than in all of the sixty-two like institutions of Paris.

The modern substitutes for *planks*, etc., are of course familiar to you. Dextrine, gelatine, caoutchouc, plaster of Paris, are all in vogue. The last-mentioned is evidently the best, for it has been under trial since the time of the elder Larrey, who, it is said, first used it; and to this day it stands the most popular. The methods of application have naturally changed as experiences accumulated. Larrey, for instance, moulded the limb in it—others put on a saturated circular bandage—others again dusted the powdered plaster over wet bandages—others still applied it with a trowel as on a wall; and so on to the end, or rather, until the arrival of Maisonneuve. The question is now settled, and all other modes are obsolete. M. Maisonneuve had once the good luck to receive a fracture of the leg, and so this method he first planned on his own person.

For example and explanation, let us suppose a broken tibia. He orders four coarse cloths, longer than the leg, and each so broad that when folded three or four times, they will be respectively reduced to a breadth of from two to four inches—the breadth, of course, varying with the limb under treatment. After these cloths have thoroughly soaked in the fluid plaster, they are taken dripping from the vessel, and directly applied along the sides of the limb. The lower ends of three of them embrace the foot and lap

intimately on the sole. The front one passes on the dorsum to the toes. A circular bandage, saturated or not, is then quickly rolled up to the knee and perhaps down again to the foot. When this bandage has not been soaked in the plaster, the apparatus is called *demi-plâtre*. In five minutes after everything is solid. The liquid splints have become firm, and every point is supported with an impartiality heretofore unapproached.

Unless when the soft parts are greatly injured, M. Maisonneuve often applies this apparatus immediately, or may be one day after the accident. This seems unsafe, and indeed I have sometimes seen most discreditable results. However, if any trouble is suspected of existing, there is no apparatus, as a permanent one, that can afford a more easy approach to the limb. And the debarrassment need be only *partial*; for after the removal of the bandage one splint, two splints, or only part of a splint, can be readily taken off, and the remainder stands firmly to its duty. If the parts thus exposed require washes, such can be used with impunity. The splints are not easily softened. In like manner are treated almost all fractures—femur, patella, clavicle, etc., etc.

A great many have failed to have success with this procédé of Maisonneuve, and it has been often because the cloth used was too *fine*. Some coarse material is the thing, such as old coarse hospital sheeting. The solution of plaster should be as thin almost as milk.

The lectures in the "progress of surgery" continue. In my next letter I will try to describe something *actually* new—namely, a urethrotome.

Army Medical Intelligence.

MEDICAL STATISTICS AT FORT MONROE.

[Army Correspondence of the AMERICAN MEDICAL TIMES.]

THE reports of the medical officers of the Department of "South-East Virginia, &c.," for the month of August, 1861, show a general improvement in the health of the troops. Fall fevers are increasing; other classes of disease show generally marked diminutions in the number of cases. The following are the figures:—

Sept. 1, 1861.—Strength of command—officers and enlisted	7361
Remaining sick on last report of regiments reported here	480
Taken sick during the month of August	2847
Sent to the General Hospital	54
On furlough	12
Discharged on Surgeon's certificate	77
Deserted	1
Died	7
Returned to duty	2734
Remaining sick, 197; and convalescent, 245	442

The cases of death were:—enteritis, 1; fever typhoid, 2; fever continued, common, 1; gastritis, 1; cirrhosis, 1; casualty, 1. These include Lieut. E. S. Holbrook, Mass. Battalion; one sergeant from 2nd N. Y. Vols.; one sergeant from 20th N. Y. Regt.; two privates from 1st N. Y. Vols.; one private of 1st Vt. Vols.; one private of 7th N. Y. Vols.

Classes of Disease.

Fevers	254
Diseases of organs connected with digestive system	1146
“ “ respiratory system	207
“ “ brain and nervous system	108
“ “ urinary and genital organs, and venereal affections	113
“ “ fibrous and muscular structures	226
Abscesses and ulcers	222
Wounds and injuries	202
Diseases of the eye	40

Leading diseases:—Diarrhoea, 718; rheumatism, acute and chronic, 209; constipation, 212; fever congestive, 33;

fever continued common, 23; fever intermittent quotidian, 66; fever intermittent tertian, 50; fever remittent, 51; fever typhoides, 5; other fevers, 26; rubella, 1; dyspepsia, 37; colica, 28; cholera morbus, 24; gastritis, 30; tonsillitis, 19; bronchitis, 72; phthisis pulmonalis, 5; pneumonia, 4; pleuritis, 11; cephalalgia, 63; ictus solis, 3; syphilis, primitive, 7; syphilis, consecutive, 23; orchitis, 16; gonorrhoea, 47; abscesses, 44; phlegmon, 80; incised, contused, and lacerated wounds, 90; gun-shot wounds, 11; contusio, 28; debilitas, 34; ophthalmia, 17; other diseases of the eye, 23.

The Medical Purveyor's office at this post is in good supply of drugs and medical stores.

Dr. R. B. McCay, of Penn., who has been acting here as a surgeon, under contract since June last, has just been commissioned as a Brigade Surgeon, and assigned to this division for duty.

CHARLES B. WHITE,
Assist. Surg. U. S. A.

FORT MONROE, VA., Sept. 17, 1861.

RECRUITING FOR THE NAVY.

[Naval Correspondence of the AMERICAN MEDICAL TIMES.]

THE receiving ship "Ohio," at Boston, Mass., receives all the recruits for the navy enlisted at the rendezvous in Boston, also from the rendezvous at New Bedford, Mass., and Portsmouth, N. H. By the Naval Surgeons Brinckerhoff, D. S. Edwards, and M. G. Delaney, all of these recruits are examined, and again re-examined on arriving at the receiving ship, by Surg. Chas. Martin and Assist. Surgeons W. K. Scofield and J. H. Macomber. The examination is conducted according to Sect. 37 of "Instructions for the Government of the Medical Officers of the Navy of the United States," which is as follows:—"Surgeons of rendezvous, or on recruiting service, will be particularly attentive in the examination of recruits. They will cause each recruit to be stripped of all his clothes, to move about, exercise his limbs in their presence, in order to ascertain whether he has free use of them; that his chest is ample; that his hearing, vision, and speech are good; that he has no tumors, ulcerated or extensively cicatrized legs, rupture, chronic cutaneous affection, or other disorder or infirmity, mental or physical, which may render him unfit for the active duties of the navy. They will ascertain, as far as practicable, whether the recruit be subject to convulsions of any kind, or has received any contusion or wounds of the head which may produce occasional insanity. With any of these defects the man will be rejected. Attention will also be paid as to whether or not the recruit exhibit satisfactory evidence of vaccination or palpable exemption from variola; that the unprotected may be immediately vaccinated by the surgeon of the vessel to which the recruit may be transferred. No person will be received into the service without having previously undergone the necessary inspection; nor will pensioners from the Naval Asylum be allowed to enter for general service."

Large numbers of trained seamen are entering the service, who are a valuable acquisition to the country in the present crisis. The navy promises soon to have more able seamen in it than the navy of France or England. The number of recruits received on the "Ohio," during the months of July, August, and September, was 3,090, being an average of about thirty-nine daily. The daily average number of men belonging to the ship during the same period was 716, and the daily average sick list, eleven.

Cases of rubella, or any contagious disease, or any case of disease or injury of a serious nature, or which is likely to last for some length of time, are transferred to the United States Naval Hospital at Chelsea, under care of Surg. J. L. Fox, and Assist. Surg. H. M. Wells. According to the new Naval Register of Aug. 31, 1861, there are in the United States Navy, eighty-five surgeons, eight passed assistant surgeons, and sixty-six assistant surgeons. There are also twenty-seven acting assistant surgeons in the volunteer navy.

W. K. SCOFIELD, M.D., U. S. N.

RECEIVING SHIP OHIO, Boston, Mass.

TO CORRESPONDENTS.

E. M. C. (Benton Barracks, Mo.)—In a note a short time since, you stated in the MEDICAL TIMES, that the First Surgeon of the Regiment ranked and wore the dress of Major. I presume this to be true, but am very anxious now to be certain of the matter. Also, inform me of the rank of the Assistant Surgeon. The statement was made on the authority of one of several Senior Surgeons of the Medical Staff of the U. S. Army. By Sec. 2, Act 18, of the last Congress, authorizing the employment of volunteers, it is enacted:—"That said volunteers shall be subject to the rules and regulations governing the Army of the United States," etc.; it provides also, for the appointment of one surgeon and one assistant surgeon to each regiment. Now, the regulations of the regular army are, that a Surgeon shall rank as Major, and an Assistant Surgeon of five years' service as Captain, of less than five years as First Lieutenant. It follows, therefore, that a Surgeon of a volunteer regiment has the rank of Major, and the Assistant Surgeon as First Lieutenant.

D. W. (St. Mary's, C. W.)—Being a British subject would not prevent you becoming a regimental Surgeon in the Volunteer Army of the United States. In most of the States, there is a Board of Medical Examiners which the candidate must pass before he is commissioned by the Governor.

D. H. (Canton, Pa.)—Communication received, will appear next week.

SPECIAL NOTICES.

SURGICAL SECTION.—The first meeting of this Section will be held on Friday, Oct. 26th, at Prof. J. R. Wood's, at 8 o'clock, P.M.

After the discussion of the subjects brought forward, Dr. SMITH, of Brooklyn, will read a paper On Fractures of the Neck of the Thigh Bone.

NEW YORK MEDICAL COLLEGE.—The Introductory Lecture will be delivered in the College on Monday Evening, 21st inst., at 8 o'clock, by Prof. C. A. BUDD. The Profession are invited to attend.

COLLEGE OF PHYSICIANS AND SURGEONS.—Introductory Address on Monday Oct. 21st, at 7½ P.M., by Prof. T. M. MARKOE.

MEDICAL STUDENT'S DAILY AND HOURLY GUIDE TO THE COLLEGES OF NEW YORK.

Session of 1861-62.

COLLEGE OF PHYSICIANS AND SURGEONS
(COR. 23D STREET AND 4TH AVENUE).

Hours.	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
9 A.M.		Smith	Smith	Smith	Smith	St. John
10 "	Dalton	Dalton	Dalton	Gilman	Gilman	Gilman
11 "	(Phys'gy)	(Phys'gy)	(Phys'gy)	Watts	Watts	Watts
	Parker & Markoe	Watts	Watts			
	(Surg. Cl.)					
12 M.		Markoe	Parker	Clark	Markoe	Parker
2½ P.M.			Detmold	(Med. Cl.)	Swift	
			(Surg. Cl.)		(Clin. for Females)	
4 "	Clark	Clark	Clark	Dalton	Clark	
5 "	Gilman	St. John	St. John	St. John	St. John	

UNIVERSITY MEDICAL COLLEGE
(107 EAST 14TH STREET, N. Y.).

Hours.	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
9 A.M.						
10 "	Metcalfe	Metcalfe	Draper	Metcalfe	Metcalfe	
11 "	Draper	Draper	Bedford	Bedford	Bedford	Post
						(Surg. Cl.)
12 M.	Post	Post	Mott	Post	Post	
2½ P.M.	Bedford	Mott	Metcalfe	Mott	Mott	
	(Obs. Cl.)	(Surg. Cl.)	(Med. Cl.)			
3½ "		VanBuren	VanBuren	VanBuren	VanBuren	
			(Surg. Cl. with Urin. Organs)			
4½ "	VanBuren	Paine	Paine	Paine	Paine	

Prof. JOHN N. MAISCH will deliver the Introductory Lecture before the N. Y. College of Pharmacy on Monday Evening, Oct. 21st, at 7½ P.M. The Profession are invited to attend.

UNIVERSITY MEDICAL COLLEGE—Introductory Address on Monday Oct. 21st, at 7½ P.M., by Prof. J. T. METCALFE.

MEDICAL DIARY OF THE WEEK.

Monday, Oct. 22.	{ NEW YORK HOSPITAL, Dr. Buck, half-past 1 P.M. BELLEVUE HOSPITAL, Dr. Loomis, Is. Hos., half-past 1 P.M.
Tuesday, Oct. 23.	{ NEW YORK HOSPITAL, Dr. Watson, half-past 1 P.M. BELLEVUE HOSPITAL, Dr. Clark, half-past 1 P.M.
Wednesday, Oct. 24.	{ NEW YORK HOSPITAL, Dr. Bulkley, half-past 1 P.M. BELLEVUE HOSPITAL, Dr. Sayre, Is. Hos., half-past 1 P.M. ACADEMY OF MEDICINE, 8 P.M.
Thursday, Oct. 25.	{ NEW YORK HOSPITAL, Dr. Buck, half-past 1 P.M. BELLEVUE HOSPITAL, Dr. Elliot, half-past 1 P.M.
Friday, Oct. 26.	{ NEW YORK HOSPITAL, Dr. Watson, half-past 1 P.M. BELLEVUE HOSPITAL, Dr. Flint, half-past 1 P.M.
Saturday, Oct. 27.	{ NEW YORK HOSPITAL, Dr. Bulkley, half-past 1 P.M. BELLEVUE HOSPITAL, Dr. Parker, half-past 1 P.M.

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N. Y. MED. COLLEGE AND CHARITY HOSPITAL
(EAST 13TH STREET NEAR 4TH AVENUE).

Hours.	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
9 A.M.	Browne		Percy			
10 "	Jacobi	Noeggerh	Cox	Jacobi	Noeggerh	Budd
11 "	Smith	Holcomb	Brown	Holcomb	Cox	Cox
12 M.	Raphael	Carnochan	Noeggerath and Budd	Carnochan	Smith	
	(Clinic)		(Clinic)			
3 P.M.	Seely	Jacobi	Smith	Seely	Jacobi	Carnochan
4 "	Percy	Raphael	Budd	Raphael	Percy	

BELLEVUE HOSPITAL MEDICAL COLLEGE
(BELLEVUE HOSPITAL).

Hours.	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
10 A.M.	McCready	Childs	McCready	Childs	Childs	Childs
11 "	Flint, Jr.	Flint, Jr.	Flint, Jr.	Flint, Jr.	Flint, Jr.	Obstetrics
12 M.	Surgery	Surgery	Surgery	Surgery	Surgery	Surgery
1½ P.M.	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital
	Clinic	Clinic	Clinic	Clinic	Clinic	Clinic
2½ "	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital
	Surg. Cl.	Med. Cl.	Obs. Cl.	Obs. Cl.	Med. Cl.	Surg. Cl.
3 "						
4 "	Flint, Sr.	Flint, Sr.	Flint, Sr.	Flint, Sr.	Obstetrics	
5 "	Doremus	Doremus		Doremus	McCready	

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